CANADA

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF THE

FATALITY INVESTIGATIONS ACT

S.N.S. 2001, c. 31

THE DESMOND FATALITY INQUIRY

TRANSCRIPT

HEARD BEFORE: The Honourable Judge Warren K. Zimmer

PLACE HEARD: Port Hawkesbury, Nova Scotia

DATE HEARD: April 22, 2021

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

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

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

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

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

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

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

Amy MacGregor,
Counsel for Dr. Faisal Rahman and Dr. Ian Slayter

INDEX

EXHIBIT LIST

APRIL 22, 2021

COURT OPENED (09:33 HRS.)

THE COURT: Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Counsel, I understand that we, at some point, had two witnesses that we hoped to hear from today, Mr. Leduc and Ms. Borden, I understand, and Ms. Borden is not available, so we'll have to find a time to reschedule her. Thank you.

I know Mr. Leduc, I take it, is here. Who is going to lead Mr. Leduc's evidence?

MR. ROGERS: That's me, Your Honour.

THE COURT: Mr. Rogers. All right, thank you.

Mr. Leduc, could you come forward, please? I'll just have you come forward and around the back row and over to the chair over to my left, please.

DEREK LEDUC, affirmed, testified:

THE COURT: Mr. Leduc, I can tell you that this courtroom, as it's presently configured, has been approved for in-person attendances and evidence by Public Health authorities, so you're free to remove your mask if you choose to remove your mask, if you're comfortable that way. If not, you can leave it in place and if you do, I'll just ask you to speak up. We do have some equipment in this room that helps to amplify the voice a little bit, but most of that comes from you.

Good, thank you.

MR. LEDUC: Thank you.

THE COURT: Mr. Rogers.

DIRECT EXAMINATION

MR. ROGERS: Thank you. Good morning, Mr. Leduc.

A. Good morning.

Q. What's your current position?

A. Currently, I'm employed as the program lead for Correctional Health Services with Nova Scotia Health Authority.

EXHIBIT P-000274 - CURRICULUM *VITAE* of DEREK LEDUC

Q. Okay. Could we turn to Exhibit 274, please?

THE COURT: So, just for the record, what's your full name, sir?

A. Derek Leduc.

THE COURT: Derek? Thank you.

MR. ROGERS: So you'll see, Mr. Leduc, on the screen in front of you, Exhibit 274. Is that your resume?

A. Yes, it is.

Q. And you've indicated your current position with the Health Authority is the program leader at Correctional Health Services?

A. That's correct.

Q. And what are your duties currently?

A. So I'm responsible for the provision of primary care, mental health and addictions, and dental services, for the four adult provincial correctional facilities for persons in custody. So I would manage the teams responsible for the direct care, so everything from development and implementation of policies, ensuring that teams are adhering to our accreditation standards, financial accountability and reporting and, of course, you know, staff recruitment and training and so on.

Q. And in terms of education that brings you to your

position today, I understand you have a Bachelor of Science with an Honours in Health Promotion from Dalhousie University in 2007?

A. That's correct.

Q. And, as well, you hold a Master in Arts in Health Promotion also from Dalhousie in 2010?

A. That's correct.

Q. And prior to you holding the position you currently hold, you held a different position with the Operational Stress Injury Clinic, correct?

A. That's correct.

Q. And if you turn to page 2 of your resume, also Exhibit 274, is that the position we see noted at the top of this page?

A. Yes, it is.

Q. What was your title there?

A. I was a health services manager.

Q. And can you describe for us the duties and responsibilities you had at the OSI Clinic?

A. Yeah. So, again, responsibility for ensuring the provision of services, the development of policies, practices, and guidelines, recruiting members of the team and ensuring they're provided with training, ensure that we're following any

sort of relevant, you know, guidelines that were provided, developing and maintaining key partnerships with Canadian Armed Forces, Veterans Affairs Canada, as well as the RCMP and others as well, and managing those internal relationships within the organization and providing certain strategic direction for the overall program.

Q. And you were the top manager of the facility, is that correct?

A. Yes, there was only one health services manager for the Nova Scotia Operational Stress Injury Clinic and that was the position that I was in.

Q. And fair to say that your role was really as manager of the facility and you were not a clinician providing services to the clients of the OSI Clinic? Is that fair?

A. That's correct.

Q. Okay. And the OSI Clinic itself, tell us the genesis of it and what the OSI or Operational Stress Injury Clinic is.

A. Yeah. So the Health Authority was approached, I believe in January of 2015, by Veterans Affairs Canada and we worked with ... we developed a steering committee that worked with the federal government to establish a memorandum of understanding to be able to operate the OSI Clinic here in Nova

Scotia, and the clinic is to provide assessment and treatment services for operational stress injuries to eligible clients and those would be members of the RCMP or the Canadian Armed Forces and veterans.

Q. And prior to the establishment of the OSI Clinic in Nova Scotia, in Dartmouth, had there been OSI clinics, to your knowledge, that operated elsewhere in Canada?

A. Yes, there are other clinics across the country.

Q. Do you recall how many there were prior to the establishment of the Nova Scotia OSI Clinic?

A. I believe we were the tenth clinic.

Q. So when did the OSI Clinic start in Nova Scotia? And I appreciate that there are various components to that start.

A. Yeah. So I'll walk you briefly through that. The MOU was signed, I believe, in May of 2015. We established a temporary site in October of 2015 and that was to allow us to be able to continue to hire and train staff. We started transitioning clients from the Fredericton OSI Clinic that were being treated here in Nova Scotia by that clinic remotely sort of towards the end of December and January, and we opened up the clinic now as it stands, in February of 2016, and the grand opening was in June of that year.

(09:40)

Q. You made reference to the New Brunswick or the Fredericton OSI Clinic. What role did it have in terms of any presence in Nova Scotia prior to the establishment of the Nova Scotia OSI Clinic?

A. So, at that time, prior to the establishment of the Nova Scotia OSI Clinic, they had a clinician who was working, I believe, out of the VAC regional office here in Halifax providing care to veterans and they also would've been ... I should say I'm not sure what other clinicians were involved at that time. We worked during that transition phase with the psychologist that was involved.

Q. And the Inquiry has heard evidence that, currently, the Nova Scotia OSI Clinic has a satellite facility in Sydney. Prior to you opening up in Burnside or in Dartmouth, was the New Brunswick operation considered to be a satellite clinic of the Fredericton OSI Clinic?

A. That's correct, yes.

Q. Okay. And then once the Nova Scotia clinic got up and running, did the New Brunswick clinic continue to operate a satellite clinic in Nova Scotia or did the Nova Scotia OSI Clinic assume responsibility for all Nova Scotia clients?

A. So Nova Scotia assumed responsibility for clients within the province.

Q. Okay, so that was sometime when you started seeing patients and opening the doors?

A. That's correct.

Q. Okay. Who operates the Nova Scotia OSI Clinic?

A. The Nova Scotia Health Authority.

Q. Okay. And so you were an employee of the Nova Scotia Health Authority when you were the manager?

A. Yes, that's correct, and as with all the employees as part of the Nova Scotia OSI Clinic.

Q. And, again, the Inquiry has heard evidence on this, but who funds the OSI Clinic even though it's operated by the Health Authority?

A. So that's funded by the federal government through Veterans Affairs Canada.

Q. Okay. And the clients, you mentioned this briefly, but the clients that come into the clinic are from what sources?

A. So the three referral sources would be through Veterans Affairs Canada, through the Canadian Armed Forces, and through the RCMP.

Q. Okay. And so when you refer to Veterans Affairs

Canada or "VAC", that's really treating ex-Forces members who are veterans, correct?

A. Correct.

Q. Okay. I want to have you briefly deal with the referral process during the time you were at the OSI Clinic. Who makes referrals into the clinic? How does an individual become a client of the OSI Clinic?

A. So the referrals would come to the OSI Clinic from Veterans Affairs Canada, usually from a case manager that would be the majority of referrals. There would be a smaller number that might come from the Canadian Armed Forces health services or RCMP health services.

Q. Okay. Can clients directly bring themselves into the clinic as clients or patients?

A. No. There is no self-referrals. Clients would need to be deemed eligible to be able to receive services at the OSI Clinic.

Q. Who determines suitability for a client to receive, or potentially receive, services at the OSI Clinic?

A. Veterans Affairs Canada.

Q. Okay. And, again, is that the case manager typically?

A. I'm not sure of the internal process. I believe it

goes to an adjudicator.

Q. Okay. Can there be referrals into the ... In the time you were manager of the client, could there be referrals into the Nova Scotia OSI Clinic from an OSI clinic operating elsewhere within the country?

A. No. So clinics could not refer directly to each other. It would have to go through the appropriate referral source which would be Veterans Affairs Canada and usually the case manager.

Q. And I'll be showing you some documents later that include some information that there was a referral, or attempted referral, in from the New Brunswick OSI Clinic. Did your client, from time to time, receive a package of materials or an attempted referral from other OSI clinics and, if so, what would you do with those?

A. So that did occur from time to time. In those instances, usually the intake team would contact the clinic that provided that referral and contact Veterans Affairs case managers. Sometimes the referral would just come a little bit later from Veterans Affairs Canada.

Q. Okay. But, in each case, you needed the approval of the case manager, approval of VAC, in order to proceed with any

referral.

A. That's correct, yeah.

Q. Okay. And what did you understand the role of VAC case managers to be in relation to a referral or any ongoing work?

A. So that they would be responsible for, you know, ensuring connections to services and treatment and other providers. Whatever would be sort of necessary based on the plan that they'd established. So they would be working directly with a client to ensure that those needs were being met.

Q. Okay. And what was the role of the client in relation to any potential referral in?

A. Yeah. So as is common within the health system, the client would need to consent to being referred to the clinic. They'd also need to consent to participate in care or assessments so the client is in the position to, of course, you know, direct the care that they're going to receive.

Q. Okay. Then following a referral in from a VAC case manager what types of assessments or services were provided by the OSI Clinic in the time you were there?

A. So the types of referrals that we would receive would be a referral for a disability assessment, a referral for a

treatment assessment, could receive a referral for a disability assessment and treatment assessment together, and a referral for ... assessment for the rehabilitation program.

Q. Okay. And, again, we've head a little bit from Dr. Rudnick and Patrick Daigle on the current process. I just want to go back to the disability assessment and have you tell me what that is and what role it has as a threshold into care or treatment for clients.

A. So that would be completed by a clinician - it's quite a lengthy assessment - and then sent to VAC and then, from there, we'd be notified if the individual was eligible to receive services. They would be making determinations that it was related to one service and a number of other factors.

So, yeah, so that would be sort of our role would be to complete that thorough assessment and to provide that to VAC and then they would determine their eligibility.

Q. And we'll talk a little bit more in a minute about the various health service providers and clinicians at the clinic, but in terms of that disability assessment, what clinician would typically be involved as part of that disability assessment?

A. So the disability assessments would involve diagnostics and so that would be completed by a psychiatrist or

a psychologist. Those would be the only two disciplines at that time that would be able to complete those assessments.

Q. And what would the typical length of time be that a client would need to be seen as part of that disability assessment?

A. It would depend on the clinician and sort of the, you know, the history of that client but, you know, it would take anywhere from, of a clinician's time, about a day to two days, depending. It's a lengthy process.

Q. Okay. So, again, you remained health services manager at the clinic until December of 2017, correct?

A. That's correct and then I would've just supported the transition to the new health services manager over the next number of months.

Q. Okay. But you were there from the inception and the time that you sort of opened your doors in February 2016, correct?

A. Correct.

Q. So taking you to the fall of 2016, that time period ...

A. Mm-hmm.

Q. ... what were the various types of health

professionals that you had on staff at the clinic available to provide services to clients?

A. So, in the fall, we would've had two registered nurses, two social workers, we would've had 2.3 full-time equivalent, so that would be spread over three ... so, for psychologists, it was three psychologists in total, but the total FTE would've been 2.3. We had an occupational therapist, and psychiatry, when we initially opened, it took a couple of months and we had a .2, so one day a week, and then at the end of that summer, that had increased to four days a week and that would've been the initial complement when we started.

Q. Okay. So that in terms of FTE or full-time equivalents, if you move from a .2 to four days, that's sort of .2 to .8 if I've got my math right?

A. That's correct, yeah.

Q. Okay. So just to go back, so in the fall of 2008 (sic), you had two RNs on staff?

A. Yes.

Q. And their role was to do what?

A. So the registered nurses would be responsible for ... so the intake process. So they would be the ones reviewing the referrals that were received. They would be following up with

case managers or other care providers to gather whatever information would be required. They would complete the triage assessment with the clients and they would bring that to the intake team, as well as the interdisciplinary team meeting for discussion. They did some work around stabilization as well but that was kind of later on.

(09:50)

Q. The Inquiry has heard evidence from Natasha Tofflemire. She was one of the RNs who was with the clinic during part of the time you were at the clinic, correct?

A. That's correct, yeah.

Q. Okay. Then social workers, you said there were two social workers on staff?

A. Yes. There were, yes.

Q. Okay. And for psychologists, there was, I understand, 2.3 full-time equivalents.

A. That's correct.

Q. Then you said 2.3 of 3, so did you have funding for more than 2.3 psychologists initially? Is that what you're referring to you when you say "of 3"?

A. It just means that that ... there were three staff that split the 2.3 FTE, so not everybody works what we call a

"1.0". Some people might only work four days a week or half-time.

Q. I understand. And then the psychiatrist, you said, evolved in 2016 from a .2 full-time equivalent staffing position to a .8, correct?

A. That's correct.

Q. And that's your one psychologist moved from one day a week to four days a week.

A. The psychiatrist ...

Q. Psychiatrist, I'm sorry.

A. ... from one day a week to ... yeah.

THE COURT: So excuse me. So a .2 is how many days a week?

A. One day.

THE COURT: So a .2 equals one day a week for a position, for a particular position. Does that apply whether it's an ...

A. That's correct.

THE COURT: ... occupational therapist, or a nurse, or a psychiatrist, a psychologist? So .2 in any of those categories is one day?

A. That's correct.

THE COURT: Okay, thank you.

MR. ROGERS: So I guess we're saying if it's a full-time equivalent, I'm assuming they work Monday to Friday, five days a week?

A. That's correct.

Q. Okay. And was there any growth, any change, any evolution in the staffing levels during the time period that you were at the clinic from, I guess, the day the doors opened until you left in December of 2017?

A. Certainly. We went recruiting for any of the vacant positions that were funded and we were the first clinic to add the occupational therapy position to be a permanent part of our interdisciplinary team. We were able to secure funding from Veterans Affairs Canada, as well, to bring on a primary care provider, a family physician. And so there was a continual process of recruitment and training and growth during my time there.

Q. And then what can you say about, generally, about the time period for recruitment of positions, let's say psychiatrists, for example?

A. So, yeah, typically, that can be a lengthy process to be able to recruit highly specialized clinicians so I believe,

initially, we were funded for 2.5, so two-and-a-half psychiatrists, and during my time there, we were able to hire additional resources from the initial .8, but it is quite a ... it can be a lengthy process which is not uncommon in the system.

Q. Okay.

Now I'd like to turn to issues dealing more specifically with Cpl. Desmond. Did you, yourself, Mr. Leduc, have any dealings with, or knowledge of, Lionel Desmond in 2016?

A. I did not.

Q. I'd like to take you next to a progress note of Ms. Tofflemire, the intake nurse, and it's Exhibit 147 and the second page of that exhibit. This is an Operational Stress Injury Clinic document titled "Progress Note" and you'll see, Mr. Leduc, at the top, it refers to a date of "2016-10-06" and I think we've heard testimony that refers to an October 6, 2016 date. Do you see that?

A. Yes.

Q. And you've had a chance to review this before your testimony today?

A. I did.

Q. So some portions of this provide as follows, and I'll ask you a few questions about that. Ms. Tofflemire's note says:

> Called VAC case manager, Marie-Paule Doucette, to discuss referral of client by NB OSI. Case manager voiced that client decided to proceed with a community therapist as he lives in Antigonish, but that she will do a referral to the clinic for psychiatry as this clinic (sic) has done inpatient at Ste. Anne and requires psychiatry follow-up. She will verify if he has a family doctor before proceeding with the referral. The file will be placed on hold until then.

And I'll take you to various portions of that, but this references the client deciding to proceed with a community therapist. What can you say as to whether that was a common or unusual practice where a client has elected to receive some services in the community other than through the OSI Clinic?

A. Certainly. So I can say that that is a common occurrence. There are a large number of providers in community that can treat veterans with OSIs. The OSI Clinic is, of course, one option and veterans do have the right to sort of choose and determine where they would like to receive services.

Our mandate would've been not to duplicate any services but we would work collaboratively with providers in community. So if, for instance, somebody had a good relationship with a therapist in community and wanted it to continue, we would certainly have to work with them and, you know, with the patient's consent, be able to speak to that therapist in community, and we just wouldn't duplicate any of the services that were being offered.

Q. Whose choice would it be then for which services a client might receive in the community and which services the client might receive at your clinic?

A. So a client would determine where they wished to receive services.

Q. Okay. And I'll come back to the components of Ms. Tofflemire's note that deals with the issue concerning family physician and access to psychiatry services, but I want to deal with the status of the referral. So you'll see the last line of this note from October of 2016 indicates that the file will be placed on hold until then.

EXHIBIT P-000275 - LEDUC - NS OSI DOCUMENTS

Then can I take you to Exhibit 275 and page 2 of those? This exhibit, Mr. Leduc, is titled "Agenda for IDT Meeting - October 12, 2016".

A. Yes.

Q. And you made reference to an interdisciplinary team meeting earlier in your testimony. Is that what "IDT" means?

A. That's correct.

Q. And what is the interdisciplinary team?

A. So the interdisciplinary team would be all of the clinicians, so the nurses, social workers, psychology, psychiatry. So any of the clinicians who are providing care, as well as the health services manager and the research and statistical officer.

Q. How often would those meetings occur?

A. Weekly.

Q. The purpose of the meetings was what?

A. It would be a variety of things. So it would be an opportunity for the team to discuss new admissions, assessments, treatment plans to assign cases to clinicians and an opportunity for them to consult on other cases and to get feedback on treatment plans and whatnot.

Q. And was this part of the collaborative approach within the clinic that you referenced earlier?

A. That's correct.

Q. Typically, were then notes made of these meetings?

What is it that gives rise to us having this document that shows the agenda for the IDT meeting of October 12, 2016?

A. So clinicians would indicate if they had a client or a file that they wanted to present or to discuss, and so it would be added to the agenda. This sort of brief note would be used by our research and statistical officer to ensure that our database is being updated and that's how we tracked everybody who was coming into or out of the clinic and, you know, who their clinician was that was assigned and so on.

So if the clinician did, you know, discuss a case or was going to be making changes to a treatment plan or whatever may have taken place, it would be up to that clinician to write a note for the patient's chart.

Q. Would these notes then typically be placed on a client's chart?

A. They would not.

Q. Why is that?

A. Because the clinical documentation would be written by the clinician and then placed on the chart. Sort of intent of this very brief note was to ensure that our research and statistical officer would be able to update quickly the database and provide a quick reference for what was discussed in the

meeting.

Q. Okay. And we see under this particular document, page 2 of the exhibit in front of you, has four headings that say "New Clients Assigned", "New Internal Referrals", "Review of New Assessments", and "Review of Ongoing Clients". And there are a number of redactions or blacked-out areas. Those are names of other clients, correct?

A. That's correct.

Q. And those are all names of someone other than Cpl. Desmond, correct?

A. That is correct.

(10:00)

Q. But we do see that Cpl. Desmond's name has not been redacted and the note there says, "Lionel Ambrose Desmond. Natasha, close file". What does that mean?

A. So it would mean that Natasha would've discussed it and indicated that the file was to be closed.

Q. And the note we looked at earlier from Ms. Tofflemire that said "placed on hold", is there any distinction between placing a file on hold or closed or what can you say about any interaction between those terms?

A. So if a file was placed on hold or a client was put on

hold, that would mean it would sort of be available that if we were contacted by the case manager and the referral source and they'd indicated they wanted to proceed, that we would be able to do that without requiring a complete new referral. If it's closed, the file is closed off, and if they were then to want services from our clinic, they would each go through the process and do a new referral.

Q. Okay. So two questions for you. Do you remember being present at this October 12, 2016 meeting and, if so, do you remember any discussion about the Desmond referral and the file being closed?

A. I don't recall anything specifically and I can't confirm with complete certainty that I was in attendance, although I did attend the majority of all IDT meetings.

Q. Okay, but you have no recollection today of that discussion involving Cpl. Desmond at that IDT meeting.

A. I do not.

Q. Okay. Did the OSI Clinic, during the time you were there, Mr. Leduc, then have any bring-forward system to reopen, re-examine a file where an event occurred such as occurred with Cpl. Desmond where the file was closed?

A. Not at that time. The expectation would be on the

referral source or the case manager to recontact the clinic if they were proceeding or, you know, if additional pieces were required for that referral.

Q. Okay. And I said earlier that I was going to come back to the portion of Ms. Tofflemire's note that made reference to the interplay between a client having a family physician and access to psychiatry services. So if we go back to Exhibit 147 - and you're way ahead of me - at page 2. So we have that note that again makes reference to this interplay between a client having a family physician and access to psychiatry services, and Ms. Tofflemire indicates that she, meaning the VAC case manager, will verify if he has a family doctor before proceeding with the referral, and that's clearly a reference to a referral for psychiatry.

At that time, in the fall of 2016, so October, what was the practice or policy at the OSI Clinic as to whether a client needed to have a family physician in order to access psychiatric services at the clinic?

A. So, in the fall, there wouldn't have been a policy, per se, but that would've been reviewed by the interdisciplinary team and determinations would be made on a case-by-case basis whether or not that referral would make its way to our

psychiatrist.

Q. Then who would make that assessment?

A. So that would be discussed by the clinical team, including the psychiatrist.

Q. Okay. And do you know what ... and so if it was done by a case-by-case basis does that mean that, in some cases, if a client did not have a family physician, then they would not be offered psychiatric services at the clinic, in other cases, even though they didn't have a family physician, they would have access to psychiatric services?

A. That's correct.

Q. Then do you know what the genesis or the rationale was behind that assessment where, in some cases, a client needed to have a family physician and in some cases, they didn't?

A. Yeah. So that would've been sort of ongoing discussions that were being had with our psychiatrists, as well as the clinical team, you know, with concerns around being able to provide sort of comprehensive, overall care for clients who were coming in with really complex health needs.

It was not uncommon for, you know, the primary care providers and family physicians to play a really critical role in community in working with those clients, and our psychiatry

model at that time would've been a consult psychiatrist, so they wouldn't have maintained a large treatment caseload, but they would've, you know, provided assessments and recommendations and maybe adjusted medications and then referred them back to their primary care provider.

Q. And when you say "a consult psychiatry model", can you elaborate on what that means?

A. So that just means that the psychiatrist wouldn't be maintaining a really large treatment caseload and seeing the patients really frequently. We had very limited psychiatry resources at that time and there was a need to complete those disability assessments as that's kind of a first step in order to being deemed eligible to receive services, so we had to really look at how to best optimize the psychiatrist's time and we had such a limited resource.

If somebody wasn't able to receive, or if they were recommended they receive psychiatry services in community, there were a number of providers that would've been available.

Q. Okay. When you say "very limited psychiatry services that were then available", does that capture even the situation once the psychiatrist had moved from a .2 FTE to a .8 FTE? Did the .8 FTE still represent limited psychiatry resources?

A. That's correct, yeah. The funding on the original sort of complement was 2.5 FTEs for psychiatry.

Q. Okay. And were there any other concerns that you heard from clinicians that gave rise to that case-by-case assessment in relation to access to the psychiatry services?

A. I think just in reference to a building wait-list, when there are sort of limited clinicians that can provide specific assessments or specific diagnostics, it can certainly generate a wait-list and delay care.

Q. Then, as a result of those issues, were any steps taken by you or the OSI Clinic to address the issue of some clients not being able to access psychiatry services at the OSI Clinic where there was not a family physician?

A. Yes. Well, I would've had some discussion starting in the summer of that year with Veterans Affairs Canada as well as our national OSI network, as well with our leadership team and our Department of Psychiatry as well, and we determined that the best approach for us would be to submit our formal request to Veterans Affairs Canada to receive funding to be able to hire a family physician to work as part of our interdisciplinary team.

Access to family physicians was an issue that also existed in other provinces as well, and there were some clinics that did

employ a family physician or a nurse practitioner.

Q. Okay. And then was there an internal step that needed to be done first in order to get Health Authority approval to make that request to VAC?

A. Yes, that's correct. So there would be a number of individuals who would've reviewed the SBAR, which is the document we had submitted, internally to provide feedback. So that would be from my sort of senior leadership team as well as through psychiatry.

Q. Okay. You just referred to an "SBAR" or an "S-B-A-R". Could we go to Exhibit 275, page 8, of those materials? This is a documented titled "Operational Stress Injury Clinic SBAR". What does "SBAR" stand for?

A. "Situation Background Assessment and Recommendation".

Q. Okay.

A. And it's just a means to communicate information clearly and concisely to senior leadership.

Q. Then was this an internal Health Authority document making a request or recommendation? You were making that to senior management?

A. That's correct.

Q. And the recommendation we see at the bottom, it says,

"Health services manager to submit formal request for funding from VAC for a .3 FTE family physician to work as part of the interdisciplinary team and work with the program leader and director to obtain required approvals within NSHA and DHW if needed." Was that the recommendation you were making?

A. That's correct.

Q. And was this essentially the document that you generated, or your team generated, and presented as part of that request for family physician funding from VAC?

A. Yeah. So I would've wrote the document and consulted with my program leader, director, and others, yeah.

Q. There's a date at the bottom of it that looks as if it's created November 30, 2016. Is that the date of this request?

A. I believe so.

Q. Okay. And then if we go to the situation at the top, it says:

> Nova Scotia Health Authority operates the Nova Scotia Operational Stress Injury Clinic as per an MOU with Veterans Affairs Canada. The agreement includes a provision of comprehensive assessment and treatment

> services by an interdisciplinary team. Psychiatry is a critical part of the OSI Clinic's model of care, and in order to receive psychiatry services, clients must have a family physician. Effective January 3, 2017, the OSI Clinic will no longer be providing psychiatric services to clients without a family doctor.

(10:10)

So in that last line where it says that as of January 3, 2017 ... obviously it's no longer going to be a case-by-case assessment, but the clinic will not provide psychiatry services if a client does not have a family physician. Did that represent a change from the practice that would've existed up to January 3, 2017?

A. That's correct.

Q. Okay. And then the background assessment is some of the same rationale for that approach and the request for a family physician funding that you referred to earlier.

A. That's correct.

Q. Okay. Then internally within the Health Authority was there agreement, a sign-off, on the recommendation and the

approach being made to VAC for funding?

A. Yes.

Q. So can I turn next to page 9 of the same exhibit? And if we could flip to the next page, page 10, just to show the signature line. This appears to be a letter from you, Mr. Leduc, and if we go back to the previous page, at page 9, we see that it's a letter from you to Dr. David Ross, the network manager and national clinical coordinator of the OSI national network with Veterans Affairs?

A. That's correct.

Q. What was the purpose of this letter?

A. The purpose of the letter was to submit our formal request for funding to support the establishment of a family physician as part of our interdisciplinary team at the OSI Clinic and for that funding to be permanent and ongoing.

Q. Would this have come out of the blue to VAC and to Dr. Ross?

A. No, it would not, no. We started conversations many months earlier about the potential.

Q. Okay. And the request, in the first line, is "Request funding approval for a .3 FTE family physician to work as part of our interdisciplinary team". Was that the ask?

A. Yes, it was.

Q. And then again we see the reference in the second line, it says, "Effective January 3, 2017, the Nova Scotia OSI Clinic will no longer be providing psychiatric services to clients without a family physician." And, then again, part of the rationale is provided there, including the last line that says, "Managing physical health issues outside the scope of practice for psychiatry requires effective, collaborative care." Is that, again, part of the rationale for saying why the change in practice was occurring?

A. Yes.

Q. And then did, in fact ... I guess two questions. Did VAC approve that funding?

A. VAC provided approval very quickly.

Q. And I'll come back to that, but then even though VAC did approve the funding effective January 2017, did the clinic, as of that date, start declining psychiatry services where clients did not have a family physician?

A. Yes.

EXHIBIT P-000289 - LETTER DATED DECEMBER 13, 2016, TO CORI FERGUSON FROM DAVID F. ROSS

Q. Okay. And going back to the approval from VAC, could

we go to Exhibit 289, please? Are you familiar with this document?

A. Yes, I am.

Q. What does it represent?

A. That would be the approval from Veterans Affairs for the amount requested and for then for us to be able to hire a family physician.

Q. And I think you said earlier that approval came very quickly and I see this is dated December 13th, I think, correct?

A. Yes.

Q. And so, obviously, no pushback from VAC in approving a family physician coming in as a funded position?

A. No. VAC was very supportive.

Q. Okay. So what were the next steps taken in order to achieve that goal that was subject to the recommendation?

A. So there'd be a number of sort of internal approvals that would be needed and some consulting with other departments, so like family medicine and through our senior leadership team, through the appropriate senior leaders. So there's a few individuals that would need to sign off. We also sought support around the recruitment piece as well for the family physician.

Q. And when did the recruitment produce a family

physician at the clinic?

A. I believe it would've been about five months later, I think in June of 2016, would've been when the physician started, I believe.

Q. Okay.

A. It may have been a bit earlier.

Q. I'll take you to a document and see if that assists your recollection of the timing.

A. Okay.

Q. If we go back to Exhibit 275 and page 17 and, actually, the document starts at page 15. Go there, if we could, first. This is a document that's been produced. It's titled "OSI Clinic Updates - April 5, 2017". And then there are three pages of that update. Are you familiar with this document?

A. Yes.

Q. What was the purpose of these clinic updates?

A. These were just regular updates that were provided to our team just so everybody's aware of the developments and things happening from the clinic and to really be sent to my program leader at that time as well.

Q. To your program?

A. Leader.

Q. Leader.

A. So my supervisor as well, just so she'd be in the loop and aware of what was happening.

Q. Okay, great. Then can we go to page 17 of the same exhibit? And the heading here says "Staffing Updates". And so we see reference to a physician starting next day and will be working one day per week, reference to a social worker starting on April 17th. Clinical directors refers to the fact that the Department of Psychiatry has approved a clinical director position for the OSI Clinic, and I assume that's the position that ultimately Dr. Rudnick came into?

A. That's correct, yeah.

Q. We see a reference to a social work position posting for a 1.0 FTE psychology position, but the one that I want to direct your attention to to assist you and see if it assists on the timing for a family physician, it says, "All required approvals has been received and recruitment is in its final stages. The expected start date is April 25." Does that assist at all in terms of timing or was there a month or so delay after this?

A. I think there might've been a little bit of a delay

but I might be referring to when the physician started seeing patients, I think was in June, but he would've started earlier to, you know, meet the team and learn about sort of our processes and, you know, that sort of typical orientation phase.

Q. Then once the family physician position was being staffed at the clinic, did that address the issue as to some clients not being able to access psychiatry services as a result of not having a family physician in the community?

A. Yes, it did.

Q. Okay.

Lastly, Mr. Leduc, I want to direct your attention to January 2017. How did you become aware of the tragic events of January 3, 2017, that brings all of us here at this Inquiry?

A. I became aware from reading a news article.

Q. What did you see in that news article and then what did you do as a result of that?

A. It just described the tragedy and indicated that Mr. Desmond was a veteran and so that, you know, so that sort of triggered me to go and speak with our RSO to review to see if Mr. Desmond had any contact or was a patient of our clinic.

Q. So, at that point, you didn't know or didn't have any recollection of the attempted referral earlier?

A. I did not, no.

Q. Okay. Then what did you learn as a result of those inquiries that you made?

A. So it was my understanding that the file had been opened but the referral wasn't completed or processed and that we had closed the file and were made aware that Mr. Desmond had indicated he'd be receiving services elsewhere.

Q. Okay. And I'll just walk you through the process. The people you contacted to come up to that conclusion ...

THE COURT: Sorry, I'm going to stop you for a second. Now who would you have learned that from? When you made the comment that you closed the file because Mr. Desmond was going to be receiving services elsewhere, who would've told you that?

A. So I would've asked the research statistical officer to open ...

THE COURT: Sorry, the who?

A. It's called an "RSO position". It's the person who manages all of our quality of the database and is an integral part of that team.

THE COURT: Yeah.

A. So his role at that time would be to make sure everything is updated into the database. So I would've verified

that with him. I would ...

THE COURT: So he would go back and check whatever was written on any of the notes or any of the documents in the database.

A. Correct. He can do that, yes.

THE COURT: He wouldn't have any personal knowledge about anything other than what he read and reported back to you what he had read.

(10:20)

A. That's correct.

THE COURT: Correct? Thank you.

A. Yeah.

MR. ROGERS: Then in addition to ...

THE COURT: And, presumably, we have all the documents that were in the database? Do you know that to be correct?

A. I believe so.

THE COURT: That's correct, is it, Counsel?

MR. ROGERS: Yes.

THE COURT: Thank you. All right.

MR. ROGERS: So in addition to talking to the RSO, we see the note of Natasha Tofflemire that I took you to earlier, which is page 2 of Exhibit 147. Did you make any contact with either

Ms. Tofflemire or any of the intake nurses to review what knowledge they had of the events of October 2016?

A. So I do recall having a conversation with one of the intake nurses. I can't recall specifically which one it was, but they would've again looked up the note, reviewed it, and just had a brief conversation and indicated that, you know, our understanding was that Mr. Desmond would be receiving services in community and that we would be closing the file.

Q. Okay. Then did you follow up at all with anyone at Veterans Affairs again concerning the tragedy and the steps that had been initiated back in October 2016?

A. Yes. So I would've had a phone call with, I believe it was the case manager, and as well as a phone call with our national clinical coordinator, and that is just for us internally to determine and make sure that all of our processes were filed and that there wasn't anything that should've been done because, if that was the case, we'd want to make sure that we can make changes immediately to ensure it wouldn't impact any other patients or clients.

Q. So let me walk you through those two. So you said you talked to the RSO, you then talked with an intake nurse. I understand you can't recall if it was Ms. Tofflemire or the

other nurse. And then you said you called the case manager. What do you remember of that discussion with the case manager?

A. I can't remember the specific conversation but what I do recall is that I was confident at that time that the referral had not been completed and the file was closed and that we were informed services would be obtained in community.

Q. Okay. Then beyond that discussion, you said that you talked with someone else in Veterans Affairs. Tell me about that person and the nature of the discussion.

A. Yeah. So that would've been a call with the national clinical coordinator for the OSI Clinic, as well as would've had my program leader and director involved at that time and, again, to verify the information that we had, and that was his understanding at that time as well is that the referral wasn't process, the file was closed, and he would be receiving services in community.

Q. And the national clinical coordinator for the OSI Clinic, is that a VAC position?

A. Yes, it is, yeah. So there's a dual reporting structure.

Q. Okay.

A. So VAC and Nova Scotia Health.

Q. So somebody at the senior management level.

A. That's correct.

Q. Over and above the clinical manager who you talked to.

A. So, yeah, the national network manager and clinical coordinator is the same person.

Q. Okay. And then as a result of the tragic events of January 3, 2017, were there any changes made in the internal policies or practices at the OSI Clinic?

A. Not to my knowledge.

Q. Okay. Thank you, Mr. Leduc, those are all my questions, but I expect there'll be questions from others.

A. Thank you.

THE COURT: Mr. Murray? Mr. Russell? Mr. Russell.

MR. RUSSELL: Yes, Your Honour.

CROSS-EXAMINATION BY MR. RUSSELL

(10:24)

Q. Good morning, Mr. Leduc.

A. Good morning.

Q. I'll start by asking, I guess ... I want to be very fair, so would you agree that the OSI Clinic, as it existed in its infancy in fall of 2015, even when the Lionel Desmond

referral came in in October of 2016, the OSI Clinic today has made great advancements.

A. Yes.

Q. And its operations are quite more detailed, sophisticated. Resources are quite a bit higher now than they were back in 2016?

A. So what I can say is that during my time, we continued to evolve as a clinic and to improve our processes and to really ... our ability to provide treatment and training and education, and so that's something that, you know, I would expect would've continued and continued to be improved and become more efficient and so on.

Q. You have clear knowledge of FTEs, what they were at the time when you were there, and you have some sort of understanding of what they are now in terms of staffing with psychiatry. We'll use psychiatry for an example. There's a major, major difference between psychiatric services at the OSI Clinic in October of 2016 compared to what they are today. Would you agree?

A. Yeah, I'm not familiar with the exact FTE, but I do know there was hiring ongoing when I departed. That would've been a substantial increase.

Q. Yeah. And I believe when you left you said there might've been two psychiatrists?

A. That's correct.

Q. And were those two psychiatrists working every day?

A. No.

Q. How many days a week were each one working?

A. So the one would've been the original psychiatrist at four days a week and then we hired a second psychiatrist who worked one day a week.

Q. So you at least have five days a week worth of psychiatrists on staff by the time you left.

A. That's correct.

Q. And it might even be more now today.

A. I believe so, yes.

Q. Back when Lionel Desmond's referral comes through October of 2016, you had the equivalent of one part-time psychiatrist who was there one day a week.

A. So the increase in our psychiatry would've started, I believe, in August of 2016, so that would've been up to four days a week at that time.

Q. So are you saying in October, you had a psychiatrist there four days a week?

A. I believe so.

Q. You believe so or you know so? You were the ...

A. That's my recollection, yes.

Q. So I'm going to ask you. And we know that you were top manager at the time in 2017. How certain are you that there was a psychiatrist there four days a week at the OSI Clinic in Nova Scotia?

A. I'm confident.

Q. You're confident that was the case.

A. Yes.

Q. How critical is a psychiatrist to the role of an OSI clinic?

A. It would be a very important part of the interdisciplinary team.

Q. Fundamental.

A. Yes.

Q. In order for an OSI clinic to operate, would you say you really need a psychiatrist?

A. That would certainly be ideal, yes.

Q. Ideal or could you call yourself an OSI clinic without a psychiatrist?

A. The only reason why I refer to "ideal" is there was a

short time when we opened our doors before our psychiatrist started, so we were still able to do some of that work, but, of course, now the model would include a psychiatrist, yes, as a critical part of the team.

Q. Yes. So what is the fundamental role of a psychiatrist in an OSI clinic?

A. So they would provide, you know, assessments and treatment, medication consultations. They would work collaboratively with the interdisciplinary team and engage in clinical discussions and they would collaborate with other care providers as well so they might provide information back to a primary care provider who is going to be seeing a client more regularly and managing their other issues.

Q. And your part-time psychiatrist in October, were they performing all of their roles in the OSI model or were there limited aspects; they were only performing some of their duties?

A. That may be difficult for me to say.

Q. I'm going to ask you. You testified about the role that the psychiatrist had played in October of 2016, so I'm just trying to grasp were they doing everything that they would maybe do at the end of your management term? You said, The role of the psychiatrist - and you talked about a large caseload - it

was in a consultation model and for an adjustment of medications.

A. Correct, yeah.

Q. Were they involved in treatment planning of clients at the OSI Clinic?

A. Yes.

Q. Were they involved in assessments?

A. Yes.

Q. Ongoing assessments?

A. It depends. They might receive an internal referral for an assessment. It would be discussed by the interdisciplinary team.

Q. Earlier, we had heard evidence of Ms. Natasha Tofflemire. She had testified on ... if I could have one moment to check the exact date. She testified here on March 9th of 2021. If I could have one moment, Your Honour. I'm trying to orientate myself. I did have it, Your Honour, I promise.

(10:30)

THE COURT: Sorry, what are you looking for?

MR. RUSSELL: Page 95 of the transcript. Mr. Leduc, if you see that there, this is Ms. Tofflemire's testimony as it relates to ...

> She was asked questions about the rationale between a family physician being a prerequisite for psychiatry. In the middle of the page at line 10, you see, the question was asked, Do you know the rationale for that or if it's something you can speak to? If you can't speak to it, that's fine.
>
> She said: I believe it was a rationale for administrative purposes but that was beyond the scope of my role with the OSI.

So, at that point, she's asked to sort of explain the rationale between why a family physician was a prerequisite or a requirement or a ...

MR. ROGERS: Your Honour, I apologize for interjecting Mr. Russell. I just quickly glanced at the top of the page and I thought that the introduction is, and I may be wrong because I just quickly glanced, I thought the introduction to that question, if you look to the top of this page, was a question about a referral in from a different OSI clinic. If you scroll back, I may be totally wrong on that but I'm not sure it was a question about the family physician question on this page.

THE COURT: I don't think it is but I think there was a question, I think that there was more discussion that took place and we don't have all of that page. Because there's there's an answer that starts on page 94, it goes to 95. "So even when you were involved," and then it goes back. If you can clarify that, that's a question that wasn't ... 94, was the previous page. Can you give me the entire page 94, just so we have it?

MR. RUSSELL: I'm just trying to pick up my spot as well, Your Honour. I'm just trying to find my spot, Your Honour. I think I can move on from the concern. One moment.

So, Mr. Leduc, I'll orientate you. I'll move on. I'll orientate you to page 111. This is Ms. Tofflemire's evidence. We had asked her last day she testified as to what the psychiatrist did at the time in October of 2016. What sort of role did they play in their day-to-day functions at the OSI clinic. If you look down at line 14, the question that is asked, and I'll read it. It would say, the question was:

> What sort of delays were there to see a psychiatrist at the OSI clinic in Nova Scotia? How long of a delay do you recall? Answer: Months. When I left, we were booking, I think, two months ahead and we

only had a part-time psychiatrist for medication management. Psychiatric medication management only.

Ms. Tofflemire's evidence when she testified was that the part-time psychiatrist was there for medication management and medication management only. Her evidence was that the psychiatrist was in a very sort of limited capacity in a role and from what I take from that is that the psychiatrist wasn't there in a full treatment model but rather a limited role. Is that your recollection?

A. That's correct, yeah.

Q. So I want to go back to sort of the original question, is: The part-time psychiatrist that was there in October of 2016, compared to when the psychiatrists that were there when you left, did they perform maybe a lesser role in the beginning, whether it was treatment planning, assessment, diagnosis?

A. I think part of the involvement around the treatment planning would be participating in the interdisciplinary team meeting and have an opportunity to be present and discuss cases with the clinicians. So they may not have been a primary clinician responsible for a specific individual's treatment plan but would have been available to have conversation, both

formally or informally, with members of the clinical team. And as part of providing medication management, they would complete an assessment to go through that process. I can't recall the specific date when our psychiatrist would have started doing disability assessments. There was a lot of new staff being hired and a lot of training and so on, but that would have been part of that role as well around that time.

Q. Would you agree that in October of 2016, the part-time psychiatrist played more of a lesser role than what they did by the time you left in 2017. Their duties were different, less so.

A. I don't know if their duties were different, per se, but they were certainly more involved and available and maybe more integrated. You know, I mentioned there was an ongoing process of evolution that would have an effect on the team. So the scope of the work would be similar.

Q. But they became more involved and available towards the end of your involvement in 2017 compared to what they were in 2016.

A. I think that's a fair statement.

Q. And more involved and available in terms of diagnosis, treatment plans, more frequently meeting with clients?

A. Yes, so they would have more clinical time available.

Q. Yes, so they would have had less time available in October 2016 than they did when you ended up with two psychiatrists five days a week in 2017.

Q. Yeah, that's correct. At that time, there was also, there were committees that were established that were, you know, developing. You know, guidelines and forms, and we were having meetings as a team. We would be establishing, you know, different practices. With a new clinic, there's a lot of other steps that are necessary to get to that point where you can sort of function very optimally and so that would, again, take up some of that psychiatrist's time and that psychiatrist also would be participating in some training, had an opportunity to visit another OSI clinic and whatnot. So there is an orientation period as well that would have been, you know, occurring throughout that period of time.

Q. Okay. So would you say your position perhaps is different than what Ms. Tofflemire testified in that the role of the psychiatrist in 2016 was beyond limited to medication management only?

A. Yeah, I would agree with that statement, again highlighting their role at the IDT meetings.

Q. So your position is they were involved in more than just medication management.

A. Correct.

Q. What else were they involved in?

A. So I mentioned previously, so participating in some of those team meetings, being present at IDT, being consulted formally/informally by their clinicians on that team. So there were a number of things that they would have been involved in at that time.

Q. And the psychiatrist in 2016 was one psychiatrist, I understand?

A. That's correct.

Q. Who was the psychiatrist?

A. It would have been Dr. MacDonald.

Q. Dr. MacDonald.

A. (Nods "yes".)

Q. Is Dr. MacDonald still involved with the clinic?

A. No.

Q. How long did Dr. MacDonald stay at the clinic, do you know?

A. I can't recall.

Q. Was Dr. MacDonald there when you left the clinic?

(10:40)

A. I believe she was.

Q. Were you getting some, as top manager, were you getting some pressures from your lone part-time psychiatrist to really build on those resources? Was she saying to you, We need to get some resources here because I'm a part-time show and it's just me. Were you getting some pressures from her?

A. I don't know if I'd call it pressure but certainly having conversations about that. The workload would be very high and sort of beyond what, you know, somebody on a part-time basis would be able to manage by themselves.

Q. And that was clearly a motivating factor as to why you reached out to Veterans Affairs to get more funding.

A. That's correct.

Q. And you had some discussions with the doctor, I understand, is it fair to say regarding, Look, we need a family physician here to take some pressure off of my role as a psychiatrist, is that correct?

A. Correct.

Q. So when you're in that position of management, is the idea and the philosophy that all people, regardless of background, get equal access to treatment. Is that sort of the

philosophy? So if someone was in a rural area versus urban, they both have a fair shot coming in the door to get access to the resources.

A. Yeah, so I would say that that's, you know, as a philosophy would be correct but, at that time, as a very new clinic, we had very limited sort of resources. We were just starting to establish our ability to provide care virtually. So I know they're in a very different position now but at that time that certainly would have been our perspective. And in instances where, you know, the OSI clinic maybe wouldn't have been the best choice for somebody to receive care, you know, with their case manager, they would have looked at resources or services or providers in their communities. So there's quite a large number of providers across the province.

Q. So, in fairness, you are trying to strive for that ideal that everyone, regardless of their circumstances, if a referral comes in, we're going to give them a fair shot of accessing our services out of Nova Scotia OSI.

A. That would be the goal, yes.

Q. I am going to ask you about the position of January 3rd. And before I ask you about that, what was your understanding of the family doctor situation for residents of

Nova Scotia as it existed in 2016?

A. Yeah, so I was aware at the time of the challenges with Nova Scotians being able to get access to primary care providers. So it was certainly a challenge facing many Nova Scotians as well as veterans who had recently left the military. I think there was an added challenge where a lot of these individuals may have been returning home from other provinces and wouldn't have access to a provider.

Q. And in fairness to anyone that was following any news story, in 2016 that was very common that people of Nova Scotia needed family physicians. There was a shortage.

A. Yeah, that's accurate.

Q. And is it fair that a shortage still exists today?

A. So I'm not privy to the specific numbers or information but, just generally from what you see in the media, that would be a fair statement.

Q. In 2016, I'm going to say there's two types of clients that can come in two doors to the OSI Clinic in Nova Scotia. There's Veteran "A", who has a family physician that can go in this door; and there's Veteran "B" that doesn't have a family physician that can go in this door. There's no difference between the two. They both have the same diagnosis, they both

have the same needs. Do you have concerns with the position that you were going to draw a hard line on January 3rd and say, You know what, veterans falling into Category "B", their door is now closed. I guess if you can explain the rationale for that.

A. Certainly. So I would say that there's still one door. What we were indicating is that the OSI with their limited psychiatry complement were not able to meet the needs of clients who were coming through the door. So the recommendation would be to Veterans Affairs Canada during that time that the quickest access would likely be through community. So the veterans would still have access to those needed psychiatry services, it's just that at that time, given our size and resources, we weren't able to meet that demand, particularly if somebody didn't have a family physician so that there wouldn't be somebody who would be able to follow them more regularly and monitor those care plans where some psychiatrists in the community would have more time to be able to meet those needs. In fact, better meet those needs at that time.

Q. So tell me about that. You had a hard time recruiting a psychiatrist. Would you agree you had a very hard time recruiting a psychiatrist for your OSI Clinic in 2016. Would you agree?

A. It's a difficult process, yeah.

Q. And why was it a difficult process?

A. I don't think I could really speak to why somebody would maybe choose or not choose to apply for the specific job.

Q. Were psychiatrists difficult to come by in 2016 in Nova Scotia?

A. I couldn't give you an answer in terms of what was happening provincially but I do know that it was an ongoing recruitment process for the OSI Clinic.

Q. Did you understand that in 2016, did you understand it was hard to get a psychiatrist in the community as well?

A. We did work with a lot of clients who were actively seeing psychiatrists in communities so I'm not aware of sort of timelines per se.

Q. But did you have some understanding that psychiatry in the community of Nova Scotia in 2016 was under a great pressure and strain. It wasn't a resource that was available in great abundance.

A. Again, I wouldn't be able to say because I wouldn't be completely familiar with all the resources that were available in community.

Q. So is it fair to say that you had no idea in 2016 how

hard or how easy it was for a veteran with no family physician to find psychiatry services in the community. You had no idea.

A. I think what I can say is that we did have a number of clients who were able to access services in community and I wasn't aware of any significant delays that would have existed. But, again, that is not something I would have been directly involved with so it's difficult for me to speak about.

THE COURT: So you were aware that they didn't have difficulty accessing services in the community. Who would advise you of that? Like where would you get the information? Did you go and actually look for it so that you could kind of compare what was happening in your clinic with what was happening in the private sector? Yes/no works.

A. It's kind of a difficult question to answer. There's no server-ready database that exists that would ...

THE COURT: I know but you offered the opinion. I'm just asking you where the opinion comes from.

A. Oh, that would just be feedback from case managers in hearing our clients were being able to be connected. We worked very closely with a number of psychiatrists on an ongoing basis so ...

THE COURT: So it's all like kind of anecdotal

discussions that you had with people. You get a feedback and you get a feeling for what's actually happening. You don't look at it statistically.

A. I'm not aware of any statistics that we could have referenced.

THE COURT: Sorry, Mr. Russell, go ahead.

MR. RUSSELL: So just, again, I'm just asking. I mean it sounds like you drew a very hard line in the sand that you were shutting one of the doors to access of OSI services in January of 2016. Did you contemplate what was on the other side for those that were trying to seek it in the community?

A. Yeah, I'm sure that was part of our thinking. But I think what we were concerned about is our ability to manage the demand and flow on our specific clinic and I had mentioned that it was a requirement for those disability assessments to happen in individuals we deemed eligible. And so, you know, if we were building a caseload, it may have ... You know, it's likely to have increased the wait times for the overall OSI Clinic as well at that time. And these were also discussions that were had with Veterans Affairs Canada, particularly with the national managers group and it wasn't something that was done in isolation but conversations internally, as well, within the

organization.

Q. In 2016, you're the head manager. Was there a supply and demand problem when it came to psychiatric services and availability in 2016. October of 2016, was there a supply and demand bottleneck on those resources?

A. At the OSI Clinic?

Q. Yes.

A. Yes.

Q. The purpose of the letter or the position that was going to be taken on January 3rd was to elevate or relieve that supply and demand for the services.

A. Correct.

Q. It was to cut off the demand. You could filter what was coming into you that you could not meet, I guess. You couldn't provide the service so you had to cut off the number of entry points, is that correct?

(10:50)

A. The intent was to clearly communicate with Veterans Affairs Canada the challenges that we were experiencing and indicating that clients who were interested in psychiatry services may be better served in community and, as mentioned, we were aware of a number of providers that were in community.

Q. And you wanted to communicate that to Veterans Affairs, I get it, but the hard line was drawn. You were cutting off some of the demand coming through the door and the rationale for that is because you couldn't meet it?

A. Yes, so I would use the term maybe redirecting to communities for some of those services.

Q. You were redirecting because you couldn't meet that service in-house at the OSI Clinic in Nova Scotia in the fall of 2016.

A. Correct.

Q. And I appreciate it's come a long way since then. I'm just trying to get a sense of whether you could meet that demand for psychiatry services as they existed in 2016.

The staff at the OSI Clinic and, in particular, the intake nurses, such as Natasha Tofflemire were ... is it fair to say that they were aware of this bottleneck problem that you had, which was demand versus ability to meet that demand for psychiatric services?

A. They would have been aware and part of the, you know, conversations at the clinical team meetings.

Q. And did they have any particular instructions as to what to say to a case manager who calls and is unsure whether a

veteran has a family doctor or not?

A. I don't believe so.

Q. Normally, would that form part of the discussion? So, for example, if an intake nurse receives a referral, discusses with Veterans Affairs case manager, and that part of the discussion, does it come up? Does the person you're trying to refer have a family physician because, if not, we may or may not be able to take them on?

A. I can't speak to what the discussions would have been between the case managers and the intake nurses.

Q. Would it surprise you if Ms. Tofflemire had that sort of discussion with Ms. Doucette?

A. No.

Q. I'm just trying to get at, you had indicated that there was no set policy, per se, that if you don't have a family doctor, you're not getting one. That was going to happen on January 3rd. But you indicated that it was assessed on a case-by-case basis. What went into that case-by-case basis of an assessment?

A. So it would have been brought to the interdisciplinary team. So the clinicians would have had a conversation about that, including the psychiatrist, would make the determination

whether or not the referral would be appropriate. But I just want to maybe take one step back and note that, you know, in order for somebody to get to that point, you know, a referral would have been completed, there would have been a triage assessment. There either would have been a disability or treatment assessment. Recommendations, you know, would have been made at that time. So there's a process involved because there may have been many other aspects of care that would have been provided or there may have been cases where that would have been received within the OSI Clinic or times when it would have been referred out to community. And part of that decision is also based on, you know, the wishes of the client themselves.

Q. And other than the one note Ms. Tofflemire made regarding her discussion with Ms. Doucette, we have no idea what happened at Lionel Desmond's intake session.

A. I don't think that there was ...

Q. Or interdisciplinary team meeting.

A. Aside from the note, no. My understanding is the file was closed.

Q. So just so I have some dates right and see if you agree with them. September 30th, Lionel Desmond receives a referral from New Brunswick OSI to Nova Scotia OSI. Do you

recall that? Would you say that's accurate?

A. So, yes, I recall that because I'm familiar with the documents but I wouldn't have been aware at the time.

Q. And then within six days, October 6th, Ms. Tofflemire speaks to Ms. Doucette, because you need Veterans Affairs to give the green light for a referral.

A. Correct.

Q. And then six days after that, we know Lionel Desmond's file is closed.

A. Correct.

Q. So we know approximately 12 days, Lionel Desmond is tipped to Nova Scotia and in 12 days he's bumped back. He's tipped to the OSI Clinic in Nova Scotia and within 12 days, he's bumped back out. Would that be accurate? His referral.

A. Yeah, I'd say not quite because the referral actually needs to come from Veterans Affairs Canada. I'm not sure if the referral was completed. We're not able to accept referrals from other OSI Clinics directly. Those go through Veterans Affairs Canada.

THE COURT: Can I just stop you while I think of it? So if the referral had not actually come through like a referral. Let's just talk about a referral for psychiatric services, for

instance, because that's what it was. If Ms. Tofflemire has a discussion with the case manager and the case manager says that she is going to confirm that he has a family practitioner in place or GP in place and that she will verify if he has a family doctor before proceeding with the referral. That was in the note. So if the referral didn't come through, there would be nothing for you, the clinic, to even to undertake because without a referral, there's nothing for you to do, is there?

A. That's correct.

THE COURT: So, at this point in time, if the referral had not come through for somebody to look at it and say, Okay, there's no referral come through so whatever we have as a file, we're going to close it. That's your decision to close it at that point in time because there's no referral?

A. It wouldn't be my decision specifically but the interdisciplinary team, they would have a conversation about it, yeah, and then they would determine if they were going to close the file.

THE COURT: There's not much of a file to close because you don't have a referral. I appreciate you have a paper file or electronic file.

A. Correct. So closed in our system and there's going to

be no follow-up or further connection and that if they were going to ... If somebody was then interested in receiving services, we would get a new referral from Veterans Affairs Canada.

THE COURT: And when case manager says, I'll get back to you, because you take your direction and instruction from Veterans Affairs Canada and, in particular, the case managers, they give you that direction, that advice, based on the basis of the terms of the terms of your memorandum of understanding proceeding on that point at any rate, is that correct?

A. That's correct.

THE COURT: Sorry, Mr. Russell.

MR. RUSSELL: So just following up with that, Mr. Leduc, when it indicates file is closed, that doesn't necessarily mean that it was a file in the sense that there was a referral and then there was a decision to close the whole file with the referral.

A. So that sort of refers to, we have a database that we use to track all the referrals and open clients and who the clinicians are and all that sort of stuff. So what it would mean is that in the database they were going to be, no longer remain active and it would be closed. So there wouldn't be an

expectation of any follow-up and that our clinic wold not be involved in any care.

Q. So you indicated that this determination of a referral that with someone that maybe doesn't have a family physician or there's the idea that they don't have a family physician, is assessed on a case-by-case basis and you indicated that that assessment takes place at the interdisciplinary team level?

A. So there would be a triage assessment that would take place. From there it would get assigned to one of our clinicians for a treatment assessment and, from there, recommendations would be made as to what is the appropriate treatment plan and what clinicians would be appropriate to be involved. That would be made at that point presented to the IDT team for discussion.

Q. I'm just going to look at Ms. Tofflemire's evidence at 112, and if we look at page nine. I guess the context for this is the questions being asked Ms. Tofflemire is about this part-time psychiatrist and the prerequisite or recommendation that they have a family physician. If you look at line number nine, it said: "So did this factor into the discussion you had with Ms. Doucette?" This is referring to Ms. Tofflemire's discussion with Ms. Doucette on October 6th.

(11:00)

Because we know New Brunswick OSI wanted Lionel Desmond to have a psychiatrist from the Nova Scotia OSI, the fact that there was a delay and only a part-time psychiatrist in Nova Scotia, did this factor into your discussion with Ms. Doucette as to what was going to happen with Lionel Desmond?

So in that question is being asked, Does the fact that you have limited, you know, part-time psychiatrist factor into the discussion with the referral agency? The answer:

It was likely a factor but it wasn't the main factor. We needed the referral and at that time, from my understanding, is she would follow up at a later date if he hadn't found services in his community.

So, to you, does that suggest that maybe he never did get an actual referral from Veterans Affairs?

A. That's correct.

Q. And, to you, do you understand that part of the discussion was perhaps Ms. Doucette was left with the impression that the clinic only could offer a part-time psychiatrist and

maybe you're better off accessing the community psychiatry.

A. It's possible. It's important to note there that the case managers would be, you know, well aware of the resources that are available in community and a number of other care providers. So the case manager likely would, in consultation with the client, determine what might be the best option for them.

Q. Was it sort of concerning to you that the intake nurse is having a discussion with the referral agency at the first point of contact and saying, Look, we might not be able to offer the psychiatric resources that you need. We are an OSI clinic in Nova Scotia, but we might not be able to actually meet a fundamental aspect of the service. Was that a concern at the time?

A. I wouldn't call it a "concern". I think that's ... you know, is a point that they wanted to bring up with the case manager, that would be reasonable.

Q. But is it natural for maybe a referral agency to assume that the OSI clinic in Nova Scotia has psychiatric services available, if requested? Is that a reasonable thing for a referral agency to have an understanding that, We make a referral to OSI Nova Scotia for psychiatry, they're going to

have the resources to meet the need.

A. So, you know, I think the expectation would be when a referral comes in, we go through our standard process, which would include a detailed assessment. And that assessment would provide recommendations, which in those recommendations may include the provision of those services by OSI or a recommendation that they're accessed in community. So that's ... and that also would extend to, you know, somebody needed services for a specific type of therapy. If there was a significant wait involved, they may have a discussion with the client and determine to receive that service also in community.

Q. Towards the end in 2017, to your awareness, were you or anyone else communicating to referral services that, We might not have a psychiatry resource available for you. We know you want to make the referral, but we might not have the resource available.

A. What was the date you provided?

Q. 2017. By the end of your operations.

A. Yes. So that would have been communicated to VAC. We did that formally in writing and we did have fairly regular meetings with their case managers and VSTMs or their managers for that team.

Q. Were there any limitations on accessing psychiatric services at the OSI clinic in 2017 to a referral agency?

A. So we would have processed it in the same way, so with the triage assessment and based on what the referral was for, whether it was a disability or treatment or so on. That would have been processed and those recommendations, just like any other client who came through the door, would have been provided to the case manager. And that, you know, would have included a recommendation to receive psychiatry services in community.

Q. Did you have a psychiatry resource problem in 2017 at the OSI clinic in Nova Scotia?

A. So we were funded for a higher complement than what we had, so certainly we would have benefitted from increased psychiatry resources.

Q. Did you have a bit of a resource shortage of psychiatry services available in 2016?

A. Yes. So I'd say the amount we had available wouldn't have been sufficient to meet the need.

Q. Did the OSI clinic in Nova Scotia, whether it be through intake nurses, communicate that information to referral agencies?

A. I believe so.

Q. And, in some cases, did that formulate the context of discussion as to whether or not their client that they want to refer there would be able to access the OSI services for psychiatry in Nova Scotia in 2016?

A. I wouldn't be able to speak to the conversation that would have been had with the case manager and their clients.

Q. You're familiar now with the conversation between Ms. Tofflemire and Ms. Doucette.

A. Yes.

Q. Would you agree that, as she said, it was likely a factor but it wasn't the main factor?

A. Yeah. So ... yeah.

Q. So would you agree that it was formulating some of the discussion as to whether or not a veteran gets in the doors of OSI Nova Scotia?

A. So, again, if the referral is received, we would process that referral like we would for anywhere else. If we weren't able to meet any of the specific services, so psychiatry included, we would have provided those recommendations. Part of that discussion with the case manager may also have been around looking at the resource available and potential wait times. And so they may have been aware by the resources that might have

been able to be accessed more quickly or that would be ... you know, that would be of interest to a client; for example, if it was closer to their home community. So there would be a number of factors that they likely would have discussed.

Q. I'm going to put aside the prerequisite for a family physician for psychiatric resources and put aside the fact that there was only one there part time. What was the wait time? If someone did get in the door for psychiatric services in the OSI clinic in 2016, when Lionel Desmond was referred, how long was the wait time between referral accepted and getting to sit down with a psychiatrist?

A. I can't recall specifically. That was ...

Q. Ms. Tofflemire testified that it was at least a two-month wait time. Would she be accurate in that?

A. That's likely a fair assessment.

Q. Sometimes was it longer than two months, for those that were accepted, before they could even access the psychiatrist?

A. It would be really difficult for me to be specific.

Q. I know it would be difficult, but you were the top manager of the OSI Clinic between 2016 and 2017. Would you agree you're somewhat familiar with the resources available as

it relates to psychiatric services?

A. At the OSI Clinic?

Q. Yes.

A. Yes.

Q. Wait times in healthcare are pretty important. Would you agree?

A. Yes.

Q. They would have been important to you in October of 2016 through your term ending 2017.

A. That's correct.

Q. What do you recall about the wait times for psychiatric services at the OSI Clinic in 2016 in October?

A. So I do recall that there ... you know, there certainly was a wait time in order to access services for psychiatry. And that ... you know, that was one of the reasons why in order to optimize that psychiatrist's time, there was a focus on having access to a primary care provider that can provide that ongoing monitoring and maintenance within the treatment recommendations provided from the psychiatrist. So that was something that was increasing for us in terms of the wait times. So I can't speak specifically to it but it was absolutely a concern. Eventually we did create a way of

tracking some of those wait times a little more effectively.

Q. So is it fair to say that even if Lionel Desmond got in the door of a referral and by the time it reached the interdisciplinary team on October 12th, he wouldn't have even seen psychiatry until probably December 12th, at a minimum, of 2016, two months?

A. I couldn't say that. There's a process involved on the triage where a lot of information is collected and then the clinicians have to review that and make determinations around level of urgency. And then it would come to the rest of that team. So I wouldn't have been able to predict the potential timeline had we received the referral.

Q. Okay. Was there some discussion that you were really sort of ... in the clinic, really wanted to press Veterans Affairs for additional funding in 2016?

A. We were having ongoing discussions with Veterans Affairs Canada and they were supportive of our identified need.

Q. And they did eventually provide you with the funding.

A. That's correct. Yeah.

Q. And part of your role was to sort of see where the funding was needed.

A. Correct. Yeah.

Q. And I'm just trying to really get at this dynamic of you need a family physician or it's recommended you have a family physician and, by the way, we have a significant wait time here, so perhaps you might want to look outside the clinic. Did some of ... did that position, was it somehow coloured in, We're going to put some pressures on Veterans Affairs and tell them, Look, you need to start filling the pot here or we can't do our job.

(11:10)

A. From my experience in working with Veterans Affairs Canada, they're always, you know, quite supportive if we could demonstrate a specific need or a request for resources. I think we were just being very transparent about our ability to meet that demand in needing to optimize the limited psychiatric resources that we had at that time.

Q. And, certainly, you would agree that they did meet that request in a timely manner.

A. Yes.

Q. You would ask. They promptly provided the funding?

A. That's correct.

Q. Why did it take so long to ask? You opened the clinic in October of 2015 with a very low complement for psychiatry.

You're a year later in the process. You're out there, OSI Clinic Nova Scotia service veterans in Canada. Why was it a year before the request gets out there for additional funding and resources?

A. So we would have opened ... so I think we were quite responsive to the concerns that were brought forward by the psychiatrist and the clinical team. So those were conversations that when there was the increase in FTE ... keep in mind that that individual is newly hired to the clinic at one day, then moved up to four days a week.

You know, as we became more familiar with operations, as we experienced an increase in the number of referrals, we learned a lot of things about our model of care. We had conversations with other clinics, as well. And, you know, based on that, you know, a decision was made that that would be an appropriate solution to the challenges we were facing. So I would say that, you know, as we learned from our experience in operating what was a brand new clinic, you know, we made a timely request that was supported by VAC.

Q. When did you first identify that the psychiatric resources at the OSI clinic in Nova Scotia just can't meet the demand?

A. Those are sort of ongoing conversations that would have started in the maybe early fall.

Q. Early fall of?

A. Of 2016.

Q. What sort of brought it to a head, brought it to the discovery in early fall of 2016 that, you know, the pressures ... the bottleneck has just built up? Was there anything in particular that ...

A. You know, I can't think of one specific thing, but certainly seeing the increased number of referrals, the increasing wait times, and those delays would have been something that would have been a factor we considered.

Q. We know when Lionel Desmond, prior to being referred to Nova Scotia OSI Clinic, he had spent over a year with the New Brunswick OSI Clinic which had full-time psychiatry who met with him, was involved in a treatment plan, did in-house consultations with another treating psychologist, Dr. Murgatroyd, and collaborated that way with Lionel Desmond. You do know when they made that referral to Nova Scotia they had recommended psychiatric services in Nova Scotia and a therapist in the community.

A. I'm aware of that now from the documentation. Yeah.

Q. Yes. And we know that Lionel Desmond only was involved in Nova Scotia OSI for 12 days and there's some suggestion that he made the decision that he wanted to access resources in the community. Did anyone at the Nova Scotia OSI Clinic, and perhaps you can answer why, didn't have any conversation with Lionel Desmond? Veterans Affairs always spoke for him.

A. So with our process, once the referral is received, provide some specific documentation, the next step in that process would be for the intake nurse to schedule a meeting and to go through a triage assessment. So, you know, that may not have proceeded if the case manager had indicated. That sort of decision can be received elsewhere or if the referral wasn't received.

Q. I guess the process is if Veterans Affairs said they spoke to the veteran, we don't need to speak to the veteran.

A. No, that's not what I'm saying.

Q. Oh, sorry.

A. Yeah. So what I'm saying is that in order for us to go through our referral intake and triage process, we would need to have that referral which would then deem that individual eligible to receive services. And then we would proceed, which

would include contacting the client for the initial triage assessment. So prior to that happening, if there's a conversation with an intake nurse and a case manager and they indicated services were going to be received elsewhere or the formal referral wasn't received, they wouldn't proceed with contacting that client because we don't actually have the referral for that client.

Q. So we know that some good certainly did come out of the work that New Brunswick OSI did with Lionel Desmond. Ultimately, they were able to refer him to a stabilization clinic in Quebec, which he went to. There was some success there. We know that he was traveling back and forth to Nova Scotia and New Brunswick but he did stay connected to the OSI clinic and there appears to have been some benefit from it.

Would any of that have played in the discussion between your intake nurse and Veterans Affairs Canada saying, Look, there was some success in this other province. We know he wants to access resources in the community or saying he does but can we try to see if he'll come to Halifax? Is there any of that discussion?

A. I can't speak to what would have been discussed by the nurse and the case manager.

Q. Okay. Is there any sort of philosophy that it's encouraged that if you're affiliated with one OSI clinic that you try to stay affiliated with ... and you move and you try to stay affiliated with another?

A. Again, that would be up to the individual client, working with their case manager, to determine where they wish to receive services.

Q. Okay. No further questions, Your Honour.

THE COURT: All right. Thank you. Ms. Lunn?

MS. LUNN: No questions, Your Honour.

THE COURT: Mr. Macdonald?

MR. MACDONALD: No questions, Your Honour.

THE COURT: Oh, sorry.

MR. MACDONALD: Yes. Sorry.

THE COURT: A little out of order here. Sorry. Ms. Ward? Ms. Grant?

MS. WARD: Ms. Grant has some.

THE COURT: Ms. Grant? Sorry. Thank you.

CROSS-EXAMINATION BY MS. GRANT

(11:17)

MS. GRANT: Good morning, Mr. Leduc. My name is Melissa

Grant and I'm representing various federal entities, including Veterans Affairs. Just a couple of questions for you this morning.

Just to clarify and I think you were explaining this just a few minutes ago but you would only expect a referral if a client wants to access the OSI clinic. Is that correct?

A. That's correct. Yes.

Q. So if I'm a client and I say to my case manager ... we're having a discussion and I say, I'm not interested in obtaining services. I'd rather pursue those services in the community. Would you agree that it's, for your purposes, irrelevant whether or not that person has a family physician in their community?

A. That's correct. Yes.

Q. And if circumstances changed and the referral was maybe for something specific, so maybe if a referral was for something like just telehealth or something like that for psychiatric services, is that a referral that you could then go and discuss amongst your interdisciplinary team as to whether or not that would work for you and the client?

A. You know, sort of our process, as I mentioned would be that referral would come through, there would be that triage

assessment, and then the referral would indicate whether or not it was for treatment. So it wasn't typical for people to refer in for a very specific type of treatment. It would be based on an assessment. And, of course, all that previous documentation and expertise from other areas would be considered. But the clinical team makes the determination as the best treatment for the client.

Q. And earlier my friend used the phrase "equal access to treatment". And I just wanted to clarify with you that this particular OSI clinic, that's not something that a member of the general public can access. Is that right?

A. That's correct.

Q. So it's specialized care that's available to veterans is one group.

A. That's correct.

Q. RCMP members is another group?

A. Correct.

Q. And, occasionally, serving CAF members.

A. Correct.

Q. So if a person is living in Nova Scotia with an occupational stress injury from, say, a municipal employer, first responder, they would not be able to access the OSI

clinic.

A. That's correct. They would not be able to.

Q. And you would agree that when you made the request to Veterans Affairs for additional funding, that that was met ... I believe you said quickly and ... was met quickly and positively.

(11:20)

A. Yes. That's correct.

Q. And you found them to be supportive in requests that you've made that have a foundation for them.

A. Yes.

Q. And with respect to the psychiatrist and the sort of need that developed for a family doctor, would you agree that, at the time, some of the clients were maybe utilizing the psychiatric services as almost like a primary physician and that was putting some pressure on the psychiatrists?

A. Umm ...

Q. I can give you an example. So if I went to the psychiatrist, who is a medical doctor, and I have a bunch of other things I want to talk about that are maybe more appropriate for a family physician, you could then see how maybe the psychiatrist would be having some extra burden on them that maybe that factored into your request for a family physician?

A. It's possible.

Q. And so would you agree that a family physician is more like the person's or the client's patient's director of care?

A. I don't know if I'd use the term "director of care", per se, but I would say they're the one who are, you know, going to be having most contact and, in turn, responsible for sort of all aspects of that care, working collaboratively with other specialists. So whether it was related to a specific medical issue or psychiatric issue they would be the ones who are kind of aware of that full picture and working with the client.

Q. The "full picture". So if I'm seeing you at the OSI clinic and I'm seeing maybe another specialist for something else, another specialist for something else, all those reports are going to my family doctor.

A. Correct.

Q. And, again, I think you said this at the beginning, but the client's choice as to whether or not to access your services is their choice and it's voluntary. Correct?

A. Yes. That's correct. They would need to provide a consent, yeah.

Q. So if everyone thought this was the best idea for someone, they could still say, I'd rather take services up in

the community.

A. That's correct.

Q. Thank you. Those are my questions.

THE COURT: I already called on Mr. Macdonald. He has no questions. And Ms. Miller is not with us today. Mr. Rodgers?

MR. RODGERS: Yes, Your Honour.

CROSS-EXAMINATION BY MR. RODGERS

(11:23)

MS. RODGERS: Good morning, Mr. Leduc. My name is Adam Rodgers and I'm representing Cassandra Desmond, who is the personal representative to Cpl. Lionel Desmond.

Just want to follow up on what my friend Mr. Russell was asking you. Mr. Leduc, and I want to look at this from Cpl. Desmond's perspective in the fall of 2016 when he's returned to Nova Scotia and is trying to access care. You'd be familiar, Mr. Leduc, that Cpl. Desmond had been receiving regular psychiatric care while through the OSI clinic in New Brunswick. Correct?

A. I am because of reviewing the documents.

Q. You're familiar with the file.

A. Yeah.

Q. And then he goes from there to the residential treatment facility in Montreal, Ste. Anne's, from May until August of 2016. And he returns home to Nova Scotia after that with a number of recommendations including for psychiatric care and followup, regular care.

So I just want to deal with the question as to Cpl. Desmond's choice at that point and his options. Because, you know, it may be suggested, Well, Cpl. Desmond, you know, he made his own choices and that choice was for care in the community, with the uncertainties that may go with uncertain expertise, uncertain availability within the community and perhaps that may not have been the wise decision at that point.

But I want to bring it back and maybe summarize what the other choice was which was the OSI Nova Scotia. So if I'm hearing your evidence correctly there was, in the fall of 2016, one psychiatrist for one day a week at the clinic?

A. In the fall there would have been one psychiatrist working four days a week.

Q. One psychiatrist four days a week. Okay. Because the evidence from Natasha Tofflemire was that this was mainly for medication followup and to deal with that aspect of things.

A. Yeah. So the psychiatry complement had increased. So, initially, a psychiatrist was only working one day a week while transitioning from other clinical duties and so after a few months was able to increase to four days a week. I believe that was by the end of August of 2016.

Q. So for Cpl. Desmond to decide to go to the OSI Clinic in Halifax, he would be facing a situation where he still had difficulty because he didn't yet have a family doctor. So that creates some inherent difficulties. Correct?

A. I'm not aware of whether or not he did have a family doctor.

Q. He would have to travel to Halifax and pay for that travel. Now I know he'd be reimbursed but he would have to pay for it upfront.

A. So at that time we didn't have ... and satellite sites were very much availability via telehealth. So if we had, you know, processed that referral and gone through that, it likely would have been recommended that he actually come to the clinic for service.

Q. He would have had to be there in person. So it would be about a two-and-a-half hour drive for Cpl. Desmond to get there and so he'd have to face that difficulty. And then in

addition to all of that he had a two-month wait time. So he would have been admitted but still have to wait to actually receive service.

A. As I mentioned, I couldn't provide a specific wait time because once a referral is received there's a triage assessment that gets completed and patients are prioritized from that assessment. And so that would have to take place in order to be able to determine the potential length of time to see a psychiatrist.

Q. So can you see how, Mr. Leduc, a veteran in those circumstances that Cpl. Desmond was facing, might very reasonably make the decision to reject the OSI Nova Scotia option and determine that community options might be the better way to go?

A. It would be difficult for me to speak to directly. I'm not aware of what sort of conversations would have been had with the case manager, what other service options would have been provided. There are a large number of providers across Nova Scotia, many of whom have expertise in dealing with veterans and OSIs specifically. So I'm not sure what sort of options would have been presented.

Q. Well, as it turns out, he did find a counsellor in the

area who had some expertise and some specialization dealing with military veterans. So I guess I'd ask again. Do you have a sense that it might not have been an unreasonable decision on his part to reject the possibility of going to the OSI Clinic?

A. I don't feel like that's something I could answer. I'm not aware of, again, what sort of ... Mr. Desmond would have been thinking or what options were presented or provided to him.

Q. So you can't answer that question.

A. I'm just not aware of what that conversation would have been or what options would have been provided, so it would just be a guess.

Q. All right. Thank you, Mr. Leduc. Those are all the questions I have.

THE COURT: Thank you. Mr. MacKenzie? No. You're with Mr. Rodgers. Sorry. Sorry. Ms. MacGregor?

MS. MACGREGOR: We have no questions, Your Honour. Thank you.

THE COURT: All right. Mr. Rogers, do you have any follow-up questions?

MR. ROGERS: I do have some re-direct.

THE COURT: All right. Go ahead.

MR. ROGERS: Thank you, Your Honour.

RE-DIRECT EXAMINATION

(11:29)

MR. ROGERS: Mr. Leduc, you were asked some questions about the complement of psychiatrists at the OSI Clinic in 2016 and you indicated that it started at .2 FTE, moved to a .8 FTE in 2016. And then by the time you finished up your position in the end of 2017, it had moved to 2.0 FTE. And Mr. Russell asked you some questions as to whether you were certain as to when that first increase in the psychiatry complement occurred. And he was asking you whether you could be absolutely certain that that occurred, the move from .2 FTE to .8 FTE, whether it occurred before October of 2017. So I think your evidence was you were certain that the increase of .8 had occurred.

(11:30)

Can I direct your attention to Exhibit 274 and page 11 of those materials?

MR. RUSSELL: It's the wrong exhibit. 275. 2-7-5.

MR. ROGERS: I'm sorry. 275. Thank you.

And so page 11 is a document that says, "NSOIC update - June 21, 2016". Are you familiar with this document?

A. Yes.

Q. And this was similar to one of the earlier update

documents that we looked at earlier. Is that correct?

A. Correct.

Q. It's a way of providing a brief summary of the events that had been taking place at the clinic?

A. Correct.

Q. And then if you can flip over to the staffing update section at page 13, what does this say in terms of the staffing update for psychiatry?

A. So there would be an increase in psychiatry support up to four days a week by the end of July.

Q. Okay. And the reference to the individual there, that psychiatry support, that's Dr. MacDonald who's being referred to there?

A. That's correct.

Q. Okay. So does that assist you to confirm your evidence that the increase of .2 to .8 FTE for psychiatry had occurred by the summer of 2016?

A. Yes.

Q. You were also asked a number of questions about whether the complement of psychiatrists was a bottleneck, to use the words of Mr. Russell, or was a limiting factor in terms of being able to provide services to clients or potential clients.

DEREK LEDUC, Re-Direct Examination by Mr. Rogers

Prior to the OSI Clinic opening its doors, do you have any knowledge as to how VAC case managers provided access to psychiatric services for veterans or for CAF members who were accessing services to psychiatry services in the Province of Nova Scotia?

A. So as I mentioned a few times, there's quite a number of providers that are available in community. And so prior to the establishment of the OSI Clinic, they would have been able to receive services from a private provider.

Q. And when you say "private provider", are you referring to something outside of the Health Authority system but fee-for-psychiatry services, private psychiatrist?

A. Yes. So private psychiatry funded by Veterans Affairs Canada, so outside of the public system.

Q. Okay. And then to your knowledge, did that continue to be a model or an option for veterans in order to access psychiatry services during the time you were at the OSI Clinic?

A. Yes.

Q. Mr. Russell also took you to the passage of Ms. Tofflemire's evidence where she indicated that psychiatrists were, at the time she was there, were providing medical management only and you were taken to that. And my recollection

is you indicated that the services the psychiatrists were providing were somewhat broader than that. Can you elaborate what, to your knowledge, were psychiatrists providing by way of assessment services, treatment services, at the OSI Clinic during 2016/2017?

A. So to the best of my knowledge, you know, I'm aware that psychiatrists would have been providing ... so when we talk about medication management, there is an assessment that would be part of that. So the psychiatrist would have been seeing patients directly and also was available and consulted with other clinicians on the team regarding specific cases and participated in our interdisciplinary team meetings, so having an opportunity to, you know, provide expertise on a variety of issues to the team or to potentially contribute to development of treatment plans and so on.

Q. Okay. Mr. Russell also asked you what the wait time would be, or the length of time it would typically take to access psychiatry services at the OSI Clinic after an initial referral came in from the VAC case manager. And in response to that question you indicated that there is a triage process. What do you mean by a "triage process" and how did that work and how did that influence wait time to access any services at the

clinic?

A. So once a referral is received and that information is reviewed by one of the intake nurses, they would then schedule a typically phone and sometimes in person, meeting with the client and they would go through an established triage assessment. That would then get presented, at that time, to the IDT meeting and there would be a determination around level of urgency. So if there's anything that was really significant or pressing that was determined by the clinicians, they would look at, How do you prioritize access for that individual?

Q. And was that an individual assessment as to how quickly one would get in based on that triage process?

A. Yeah. Yes, so all the treatment that was provided was highly individualized at the OSI Clinic.

Q. Highly what? Sorry?

A. Individualized.

Q. Okay. Thank you. And the Inquiry's heard evidence that in the emergency department context, there's also a triage process and an acuity scale identified to identify the range of patients and the level of urgency in terms of accessing care. Is that something that was done prior to the triage process through the OSI clinic, as well?

A. So I can't speak to what the sort of similarities and differences would be between the two but having a triage as part of intake process to a program or service is common in healthcare.

Q. If it was determined as part of that intake process that a client had urgent or emergency mental health needs, is that something that the OSI Clinic was able to provide?

A. The OSI Clinic did not provide any urgent or emergent services like that. Information would be communicated back to the case manager.

Q. What would be the situation if ... do you know what the situation would be if that were identified, that the IDT team said, This is something that needs emergent care. What would the process be for providing recommendations or accessing that type of care?

A. Yeah. I wouldn't be able to say specifically what those recommendations might be but the team would ... you know, it was common to provide information around other services that were available, so whether that was crisis services or access to a local emergency department or ... there's a ... I believe there's a VAC assistance line, as well, that's 24/7. So there is ... they may have been provided this information and other

options, as well.

Q. Okay.

A. But we certainly weren't ... the model of care did not involve any urgent or emergent care.

Q. Okay. My friend, Mr. Rodgers asked a question I think built in the premise of it was that Mr. Desmond, in the fall of 2016, did not have a family physician. And my recollection of your notes is you say: I'm not aware whether or not he had a family doctor. If a client or potential client had a family physician in the fall of 2016 or even in 2017, that first four-month period where the policy was put in place that in order to access psychiatry services it was necessary to have a family physician, if a client had a family physician, then was there any bar to receiving psychiatric services at the OSI Clinic?

A. No. They would have ... but just to reiterate, they would have went through the normal process of triage and assessment. It would have been determined if that was the appropriate treatment and we would have gone through our sort of normal process for that. But they would have been able to receive services if that was the case, yes.

Q. Okay. Can we turn to Exhibit 67, please, page 7 of those materials? So this is a note, Mr. Leduc, of a psychiatric

nurse, Heather Wheaton, from October 24, 2016, arising from a visit by Cpl. Desmond to the St. Martha's Hospital. And we see at the top, October 24, 2016 date. And we see "Family Doctor". And we see a reference to Dr. Ranjini. My recollection of Ms. Wheaton's testimony is that the information contained in this form all came from her meeting with Cpl. Desmond on that day. So if that's right and Cpl. Desmond is reporting that he has a family physician and does have a family physician, then would that have been enough to allow Cpl. Desmond to access psychiatric services at the OSI Clinic through the fall of 2016 and into 2017?

(11:40)

A. Yes.

Q. Thank you. Those are my questions.

THE COURT: Just on that point, Mr. Rogers, I know that Dr. Ranjini had testified and talked about a process, how her name winds up on a lot of documents when, in fact, she's not actually an individual's family doctor. So there is some ... I just recall that generally. So there may be a bit of caution. I'm suggesting that when you ... just because you see her name as the family doctor there, how that actually came about ... whether she actually was his family doctor at the time is

something that somebody else may want to have a closer look at.

MR. ROGERS: And I accept that, Your Honour.

THE COURT: Okay. That's all.

MR. ROGERS: It's probably not worth taking this witness to the document, but we obviously see the December visit to Dr. Ranjini where the referral is made to psychiatry. So, obviously, he was able to access the Guysborough Medical Clinic, but I don't think we need to take Mr. Leduc through those documents.

THE COURT: And it wasn't for that point that I was suggesting it. It was just, you know, to make an observation that there is evidence from Dr. Ranjini with regard to how her status appears on documents as a family doctor and when she may not actually have truly been a family doctor, but I appreciate your point, but I just raise it as reminder that that evidence exists out there, as well. Thank you.

EXAMINATION BY THE COURT

(11:42)

THE COURT: Mr. Leduc, I'm just going to just take you through some documentation. Could we have Exhibit 275? And it's page 21, please. And so I just have a question. So this

is a document entitled, "OSI Clinic Update - August 2016". And these would have been prepared by clinic staff, I take it, or someone in the clinic. Who would have prepared those?

A. It would have been myself, working with the research and statistical officer.

Q. Okay. And so there's a box at the left-hand side of the page. It says, "Psychiatric Services". It says, "Increased from 0.2 FTE to 08 FTE." And then, "Recruitment continues with support of DOP to fill remaining vacancies." Then in brackets it's "1.7 FTE". And I know that Mr. Rogers took you through another document that talked about staffing, that kind of thing. So this is an August '16th update in relation to psychiatric services. So when you say: "Recruitment continues with support from DOP to fill remaining vacancies", those are psychiatric vacancies, are they?

A. That's correct.

Q. And so I take it that that recruitment would be to find psychiatrists that would be able to fill up the available days that you had in your budget for psychiatric services?

A. That's correct.

Q. Correct? Do you remember how many you would have been looking for at that time, ideally?

A. Yeah. I can't say specifically because it's not uncommon for clinicians and psychiatrists, in particular, to split time between different programs in service area, so that kind of usually gets negotiated. And psychiatrists are actually hired by the Department of Psychiatry and provided to Nova Scotia Health. So they're the ones primarily responsible for that work.

Q. "So with the support of DOP", that's Department of Psychiatry?

A. That's correct. Yes.

Q. So the recruitment of your psychiatric staff would come through the Department of Psychiatry.

A. That's correct.

Q. And they would try and find psychiatrists that were available, interested, to fill those slots that would be available through your clinic.

A. That's correct.

Q. Okay. And that would have been and so we know that recruitment process is on at least as of August 2016. Correct?

A. Correct.

Q. Thank you. There's another document, if we could have it. Same exhibit, it would be page four, please. Now this is a

document, "Intake Team Meeting". Intake Team, is that the "IDT" or is it different?

A. That's a different team.

Q. It's a different team?

A. It's a smaller team. That would be typically the two intake nurses, myself, and the research and statistical officer.

Q. Okay.

A. There may have been others that were able to join from time to time but that was kind of the core team.

Q. If I could then on page four, if I can just direct you to the last line. The client name is blacked out. "Referred By" and the date. There's no information in that field at all. "Referred For", which is treatment. "Intake Contact", there's nothing there. "Clinician and Assessment Type", is filled in. "Date Offered" is there, it's July 11th. We go over to the very last box under "Notes". It says, "Update at IDT". Then it says, On ... "And now has GP". Sorry. So ... I guess it's "On F/L for ..."

A. Followup.

Q. For ... okay. It's "On followup for TFL". Or "TFT." Sorry. What's "TFT"?

A. I'm not sure.

Q. Been away from it too long.

A. It's been many years. Sorry.

Q. It's okay. So it was a followup for FTF (sic) and then it says, "Now has GP, so will schedule for psychiatry FU", which I take it is "followup", is it?

A. Correct.

Q. So when I read that, does that mean that when this was written, May 17, 2017, that this individual, because they did not have a GP would not be eligible for a psychiatric followup and that, presumably, is part of that January 3rd declaration?

A. That's possible.

Q. Would that be correct?

A. That's possible. Yes.

Q. Okay. Somebody may have asked it but I'll ask. When did that get lifted?

A. I can't recall the specific date but I don't believe it was very long after.

Q. Like what month?

A. Once our family physician started and once he started accepting new clients.

Q. Do you remember when your family physician started?

A. I do know it's in the documentation. I feel it was in

sort of late spring of 2016, I believe, like maybe May or June.

Q. All right.

A. Like I'm confident that it was May or June. It was that timeframe that he would have started with us.

Q. Okay. And then if we could go over to page 5 then, please. So, again, this would have been a 2017 event. And the referral was the inner-clinic file transfer, if you can see that under "Referred By" and the date.

A. Yes.

Q. It's the second item down. And then the notes and then it would way, "Awaiting VAC". And I take it that's ... you would be waiting confirmation of the referral or would that be, at that time, require a new referral from VAC? If there was an inner-clinic transfer, OSI New Brunswick transfers to OSI Nova Scotia ... file it comes to you but you cannot undertake those client services at that point in time without a referral from VAC?

A. That's correct. Yeah. So that means we may have received some documentation in advance of the formal referral being submitted.

Q. Okay. That might have been ... if you had documentation in relation to Cpl. Desmond's case from New

Brunswick, that would have fallen into the same category as that item there?

A. That's correct.

Q. That's how it would be dealt with?

A. That's correct.

(11:50)

Q. Okay. And could I have Exhibit 147, please, page 2? This was the note that we have from Ms. Tofflemire dated October 6, 2016. Now many people place great reliance on notes that are made in a medical environment. Generally, health records by a number of evidentiary rules, are considered to be very reliable documents that speak for themselves, appreciating that there's an obligation on the medical personnel that create these notes to make certain that they're accurate and reflect what they report to express. You appreciate that concept?

A. Yes.

Q. Right? So when Ms. Tofflemire writes ... so she called back Case Manager Marie-Paule Doucette to discuss a referral of the client by New Brunswick OSI. That suggests to me that it may have happened as some documentation or something came from OSI New Brunswick to OSI Nova Scotia, such as the example that I gave you in those other documents. Right?

A. Okay.

Q. And as demonstrated in the other documents, then in this case, Ms. Tofflemire calls up the case manager and speaks to Marie-Paule Doucette. That would be what you would expect the process was at the time. Am I correct?

A. Yes.

Q. Right. And then the case manager voiced that: "The client decided to proceed with the community therapist, as he lives in Antigonish, but she will do a referral to the clinic for psychiatry as the client has recently done an inpatient at Ste. Anne's and requires psychiatric followup." Appreciate that I accept that that is what Ms. Doucette expressed to Ms. Tofflemire because that's what appears to be in this medical record, that he required psychiatric followup, but he was going to proceed with a community therapist. All right? So I would have expected, at that point, that Ms. Tofflemire is ... because the clinic provides psychiatric followup, that that would be an appropriate place in the normal course of events for him to be. Correct?

A. Correct.

Q. Okay. And Ms. Doucette apparently tells Ms. Tofflemire that she will verify if he has a family doctor before

proceeding with the referral and the file will be placed on hold until then. So it appears that Ms. Doucette is the one who is going to ... she sets ... she's the case manager. Appears that she has established ... there is a prerequisite, at least in her mind, or a practice or ... just based on the words. But there's some indication that she has to establish, before she makes the referral, that he has a family doctor. Now in your experience, was that decision generally made by a case manager or was that something that comes out of the OSI Nova Scotia practice?

A. Well, there would be a lot of information that would be required as part of that referral process and there's a document that would be submitted. And so it's not uncommon for case managers to verify and make sure that information is provided. You know, it's certainly possible that they had a conversation indicating that, you know, we do have limited psychiatric services available and that they're being assessed on a case-by-case basis. And case managers, being aware of what's available in community, could discuss with their clients what might be the best option for them.

Q. When you say that at the time it was not mandatory that a referred veteran actually have a general practitioner or family practitioner before they receive psychiatric services

because you would have a discussion with your team of people and you decide whether or not it was absolutely mandatory. Am I correct? That would be a discretionary call within your clinic?

A. Yeah.

Q. Am I right or wrong?

A. Umm ...

Q. In terms of it being a discretionary call.

A. Well, it would be a discussion in terms of what the most appropriate treatment plan might be for that individual. And then the psychiatrist would weigh in whether or not that would be an appropriate referral.

Q. Well, I'm just talking about this issue of having a general family practitioner or general practitioner, whether they had one or not before they received psychiatric services, was that a discretionary call within your clinic?

A. At that time, that would have been a decision that was made by the clinical team so it was discretionary.

Q. Okay. Thank you. Do you have any idea why the case manager would take that discretionary call out of your hands and decide that they were going to determine whether or not there was a family doctor before they even made the referral, before your team could even have a look at this? Any specific idea

because of any discussions you'd had with case managers or Veterans Affairs Canada and what their rationale might actually be?

A. Well, they may have been aware of other clients who weren't going to be seen in our clinic and that where we have made following our triage and assessment referrals that would ... or not ... sorry, recommendations that would indicate ...

Q. No. I'm going to stop you because you said "may have". I want to know if you have any actual idea of what would be behind the thinking because of discussions that you had with somebody, not trying to figure it out sitting here today. But had you ever spoken to a case manager to determine what the rationale was, or someone at Veterans Affairs Canada to determine what the rationale was, or any other person who could actually say, No, case manager makes the decision.

A. So I can't recall specific conversations but they would be aware of the limited psychiatric resources. They'd also be aware, for other clients, may have referred that a recommendation is going to be seen in community. And it's likely they were seeing more of that as our resources continued to ... as we saw increasing wait lists and demand on service.

Q. You're just guessing.

A. Well, that would be ... yeah. Oh, I can't say specifically what would have been discussed. I can't recall. Yeah.

Q. In the SBAR, forget what page that is. Page 8, please, Exhibit 275. So the Operational Stress Injury Clinic SBAR, where does this ... let's see. Who's the target audience for this document?

A. So that would have been my senior leadership.

Q. Your senior leadership? Okay. And when you say ... so the first paragraph, it says: "Psychiatry is a critical part of the OSI Clinic's model of care and in order to receive psychiatric services, clients must have a family physician." Then: "The clinic will no longer be providing psychiatric services to clients without a family doctor."

Now those words are pretty specific "must have". So why, in that situation, when you're, you know, writing to your target audience do you say that they "must have" when there are situations where, you know, the team would make an assessment or an evaluation as to whether or not the individual can proceed with psychiatric services in your clinic even without a GP? Because if they must have it, then how would you decide to proceed without it in some circumstances?

(12:00)

A. So, again, that was in response or the fall to the increase in demand and the increase in wait times and our ability to meet that demand. So by communicating very clearly the fact to indicate that this was now a requirement, that instead of going through our process with the referral and the triage assessment and so on, that there be ... that, you know, if that wasn't exactly what they were looking for with that client, they would refer straight to community.

Q. Okay. So "must have" didn't mean they must have it in terms of kind of a holistic approach to the health and well-being of the individual. It's a "must have" because without it, we're getting a backlog in our system.

A. I wouldn't say that's accurate. I think there is ... in order to provide really comprehensive care around somebody's mental illness and they do have a lot of comorbidities physically that also impact, that it's very difficult to effectively manage somebody's, you know, mental illness if there are lots of complications with respect to their physical health. And, again, this is, you know, not from my ... I don't have any expertise around that specifically, but that would have been concerns and discussions ...

Q. The advice from the clinicians.

A. ... brought forward from the clinicians and from the psychiatrist specifically.

Q. Sure. Yeah. And you take guidance from them, obviously, if you think that's moving to a best practice, then that's the model you want to ...

A. That's correct. Yeah. And I would communicate that up and ...

Q. Sure.

A. Yeah.

Q. Yeah. Appreciate that.

The last document I think I'm going to have ... so it's the ... it's 275, I believe one of the first couple of pages. I guess it's page 2, please. And these are the notes from the IDT meeting of October 12th, 2016. And I know under "New Clients Assigned", and it says "Lionel Ambrose Desmond. Natasha, close file." And we understand what you said in that regard. But when you go down a little further on that same page, under "Review of Ongoing Clients" in the second item down, it's blacked out. Then it says, "Jennifer". I take it she was one of the nurses, was she?

A. Yes.

Q. Okay.

A. One of the intake nurses. That's correct.

Q. The other intake nurse? Okay.

A. Yeah.

Q. It says: "No psychiatry referral pending GP and has med refills." When I read that it says: "No psychiatric referral pending GP." Now that sounds a bit of an echo-ish of the same note that Ms. Tofflemire had written following her conversations with the case manager that there would be no referral for psychiatric services until she had confirmed that there was a GP. That seems to be the same kind of notation.

A. Similar.

Q. Am I correct?

A. Yes.

Q. Am I correct in that assumption?

A. Yeah.

Q. So would that have been a growing kind of practice out of the case managers saying that, We're not going to refer until we have a GP confirmed. Because this is now a different client that she has which appears to be experiencing the same kind of circumstances that Cpl. Desmond did. But was it a common practice for the case managers to simply say, Well, you don't

get a ... there'll be no psychiatric referral until we confirm it's a GP. And perhaps to accommodate your emerging clinical practice or what you'd like it to be?

A. Yeah. I can't state specifically. I'm not sure what aspects exactly the case manager would be referring for. Referrals for our service, I mentioned, typically wouldn't referral for a very specific service, it would be for assessment or treatment.

Q. A number of things. Yes. Appreciate that.

A. And then we would determine whether or not it was, in fact, psychiatric services or whether it was, in fact, you know, prolonged exposure therapy with a clinical psychologist or whatever might be most relevant. But I think that over time and where we made the decision to really kind of make it formal that we weren't going to be able to do that as we've seen an increase, while it was on a case-by-case basis, seeing more and more clients being referred to community.

Q. Sure.

A. Or being directed to community.

Q. Yeah. I can appreciate that as the caseload grows and your resources get stretched, you have to make decisions until you can expand one or shrink the other.

A. Yeah. And one thing I don't think I've mentioned yet is also one of the absolute benefits of the OSI Clinic is operating as an interdisciplinary team, so having all those care providers as part of that same team. So if somebody is receiving other therapeutic or treatment services in that clinic, also having access to psychiatry as part of that team is really important. So, you know, if there was somebody who only wanted psychiatric services, you know, it's possible that their needs might be better met in community. And there were cases where individuals ... our recommendation would be for them to receive services in community.

Q. Sure. Now ... and in this particular case, like page 2, we're talking about no psychiatry referral pending GP. That could result in a referral from the VAC case manager. You would look at it ...

A. Correct.

Q. Your team would look at it and you might then make a decision that this person could be best managed or best served by another resource in the community rather than at the OSI Clinic.

A. Correct.

Q. That's the point you're trying to make, I guess.

A. That's correct. Yes.

Q. Yeah, I appreciate that. But that stops ... it's at your doorstep that you make the choice or you make ... you give the opinion ...

A. Recommendations.

Q. ... at that point ... or the recommendations, rather. All right. Thank you. All right.

Well, I don't have any more questions. Thank you very much for your time, Mr. Leduc. I appreciate that it does take some time to prepare and to go over the documents and make the documents available to counsel and meet with counsel and have your discussions. I can tell from your resume that you have other matters that keep you occupied full time. So we appreciate you coming today and appreciate the time you put into preparing for your evidence today. Thank you very much.

A. Thank you, Your Honour.

THE COURT: So we'll excuse Mr. Leduc then. All that I'll ask, Mr. Leduc, I'll let you find your way back to a seat, if you'd like to stay. I just ask you to put your mask back on down the aisle. Thank you.

WITNESS WITHDREW (12:07 HRS)

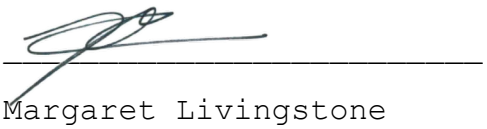
THE COURT: The other witness that we had planned for

today is not available and we're going to have to make some alternative arrangements for that witness to appear. So we're going to adjourn for the day. I just ask counsel to remain so we can have a discussion. Thank you.

COURT CLOSED (12:08 HRS)

CERTIFICATE OF COURT TRANSCRIBER

I, Margaret Livingstone, Court Transcriber, hereby certify that the foregoing is a true and accurate transcript of the evidence given in this matter, **re Desmond Fatality Inquiry**, taken by way of electronic digital recording.



Margaret Livingstone

(Registration No. 2006-16)

Verbatim Inc.

DARTMOUTH, NOVA SCOTIA

May 3, 2021