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: February 23, 2021

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COURT OPENED (09:33 HRS)

THE COURT: Thank you. Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Good morning, Dr. Joshi.

DR. JOSHI: (No audible response)

THE COURT: Not good.

MR. MURRAY: Good morning, Doctor. Are you still able to hear us?

DR. JOSHI: Yes. Good morning. Good morning, everyone.

THE COURT: All right. Have you had a discussion with Dr. Joshi with regard to his evidence, whether he wishes to be sworn or make a solemn declaration? Has anyone asked?

MR. MURRAY: We have not. I don't know. May have to ask him. Doctor, the Clerk is going to swear you in. You have a couple of choices. She's going to tell you what your choices are for being sworn.

DR. JOSHI: Okay.

DR. VINOD JOSHI, affirmed, testified:

THE COURT: Thank you. Mr. Murray?

MR. MURRAY: Thank you.

DIRECT EXAMINATION

MR. MURRAY: Doctor, can you tell the Inquiry your full name, please?

A. My name is Dr. Vinod Joshi.

Q. All right. And just so that I'm ... I want to be very careful. Your last name, I want to pronounce it properly, is JOESH-ee?

A. Correct. Yeah.

Q. Okay. And how are you employed, Dr. Joshi?

A. So I'm currently working part time at a mental health clinic in Gagetown with the Canadian Forces. So I'm a civilian contractor here. And other part-time, I work in Saint John with a community mental health clinic. So in Gagetown, I see predominantly active soldiers as my patients and in Saint John, I see civilian, like provincial ... it's a Government of New Brunswick health clinic.

Q. And how much of your time is spent in the private

clinic and how much is spent with your work with the Canadian Armed Forces?

A. So 50 percent of my time is with the Canadian Forces, other 50 percent of time is with the Saint John mental health clinic.

Q. Your relationship with the Canadian Armed Forces, are you an employee or are you a contractor? How is that ...

A. No. I'm a civilian contractor for the Canadian Forces. I'm not a Canadian Forces member.

Q. Okay. Thank you. Dr. Joshi, are you still able to hear us okay? Just your picture froze up there.

A. Yes. Yes. Yes.

Q. Okay. Did we freeze up or ...

A. Yeah, I can hear you.

Q. Okay. Are we frozen, too, or ...

A. No, no, you're fine. I can hear you.

EXHIBIT P-000174 - *CURRICULUM VITAE* OF DR. VINOD JOSHI

Q. Okay. All right. So, Dr. Joshi, I want to show you an exhibit which you provided to us. It's marked as Exhibit 174. It's your *curriculum vitae*. And I just wanted to ask you some questions about that.

A. Okay.

Q. I think we're going to bring it up on the screen.

A. Is it on? I can't see the screen.

Q. I think it's coming.

A. Okay.

Q. Are you able to see it now?

A. I need to increase the ... yes, I can see it.

Q. All right.

A. Okay. Yeah.

Q. Great. So I just want ...

A. Yes, I can see it.

Q. Okay. Thank you. I just wanted to ask you some questions then about your training and qualifications.

A. Okay.

Q. And so maybe we can start just at the beginning with your education. You received a degree, MBBS, from Bombay University. What is that degree?

A. So MBBS is a basic medical qualification that qualifies me as a doctor. In India, it's called "MBBS", which would be kind of corresponding to "MD" in North America. It's a basic undergraduate medical degree.

Q. Okay. So you received your medical degree in 1985 and then you went on to study psychiatry, I take it.

A. Correct.

Q. And I see that you received degrees in psychiatry or specialty in psychiatry at ...

A. Correct. So I join ...

Q. ... Bombay University.

A. Yeah. I joined psychiatric post-graduation qualification in India and I completed that in '89 from Bombay University in India.

Q. All right. And you have worked as a psychiatrist then since that time, have you?

A. Yes. I've been working in psychiatry since 1986, initially as a trainee and, you know, it's ongoing since then.

Q. After studying in Bombay, you went to the United Kingdom and practiced there for a period of time, did you?

A. Yes. I went in United Kingdom. I work there for four years. During that time, I completed examination which is like a post-graduate examination by Royal College of Psychiatrists in U.K. So that gives me qualification of MRC Psychiatry. I also did a Diploma in Psychological Medicine by Royal College of Surgeons in Ireland. So that was completed in 1994.

Q. I see. So did you practice in Ireland as well as the United Kingdom?

A. No. I practice in United Kingdom. This exam was held by Ireland so I just went there for exam.

Q. Right. Okay. And you were there in the United Kingdom, you said, for four years?

A. Correct. Yeah.

Q. And at some point you came to Canada. When did you do that?

A. So I came in Canada in February 1996 in Saint John, New Brunswick.

Q. All right. And just before we move to your work in Canada and in the Province of New Brunswick, there was one part of your education I wanted to ask you about. You were a PhD candidate and you studied ...

(09:40)

A. Yes.

Q. ... or did work on the issue of PTSD in Bhopal Gas Disaster victims. Is that the first time that you became interested in post-traumatic stress disorder or that you studied it?

A. Yes. I think that was the first time I got involved more intensely with PTSD. So this was related to the industrial accident in 1984 in India and there was a lot of PTSD in that

particular city, so we were involved in collecting data information about the prevalence and study in that population. Unfortunately, I left India to ... went to U.K.; therefore, I couldn't complete the PhD.

Q. The Bhopal Gas Disaster was obviously a very significant event. You had said a little bit about it. You might remind us what happened.

A. So there were industrial Union Carbide plant which leaked a chemical called methyl isocyanate and the gas leaked into population at night. And there were ... if I remember correctly, over 2000 people died and over 100,000 people were suffering from various physical and psychological trauma. So the ... I mean the victims were eventually exhibiting a lot of signs of PTSD. And the study was kind of done in the context of submitting the report to the courts for compensation-related issues about the victims.

Q. There was significant trauma, I would take it, after that and many people who were suffering from post-traumatic stress disorder.

A. That's correct.

Q. Did that continue to be an area of interest for you for study and treatment?

A. So then I went to U.K. So I studied various subspecialty in psychiatry. And you would see PTSD patients, you know, in civilian population in England, like any other psychiatric condition. So it was part of general, you know, experience in multiple psychiatric disorders or conditions. So it was not specifically geared towards PTSD while I was in England, it was rotating through different subspecialties of psychiatry.

Q. Right. Okay. And your area of psychiatry, would you call it adult psychiatry?

A. Correct. It would be adult psychiatry, yeah.

Q. Okay. And that would be the treatment of all psychiatric conditions that an adult may incur?

A. Correct.

Q. All right. So you said you came to Canada in 1996 and ...

A. Uh-huh.

Q. ... specifically to the Province of New Brunswick. What brought you to New Brunswick?

A. So as I was finishing my degrees in U.K., I was exploring different options. So at that time I was contacted by the recruiting organization here in Saint John. So one thing

led to another and I decided to come to Canada.

Q. Okay. And, initially, you worked for Mental Health Services, Horizon Hospital, in Saint John, New Brunswick?

A. Yes, I did. Yeah.

Q. You said specifically from 1996 to 2007 you were working with serious mental illness and forensic psychiatric teams. What was the ...

A. Yes.

Q. ... nature of the work with the serious mental illness and forensic psychiatric teams for Horizon's Hospital?

A. So, at that time, Saint John, New Brunswick, was going through deinstitutionalization. So there was an old psychiatric hospital called Centracare that was downsized. So, at one point, it had over 400 patients. And the new hospital was being built with 50-patient capacity. So we developed a team of community mental health services to facilitate patients who were in psychiatric hospital and settle patients in community. So it was kind of getting out into community and establishing their, you know, life in community. So I was part of that team.

So, in that, there were many people who might have conflict with the law when they were sick. So it started at the downsizing of the Centracare, or the psychiatric hospital. But

in due course, we started to get more and more patients from community who were freshly diagnosed with psychiatric condition. And then, over time, it became ... you know, patient we'd see has mental illness like schizophrenia, bipolar disorder, autism, different other complex personality disorders. So that was my main role.

Q. All right. And a wide range of psychiatric conditions that you'd be dealing with in that capacity?

A. That's right. Yes.

Q. So in 2007, it was then that you began your work with the Canadian Armed Forces, was it?

A. That's right. So in 2007, there was a major rota that went from Canadian Forces to Afghanistan from Gagetown. So the Forces were anticipating, you know, high psychiatric problems after members coming back, so they were recruiting psychiatrists from the Province of New Brunswick. So I got interested and I approached and that's how I started working in Gagetown. Then I down ... I mean I moved from full time in Saint John to part time. So since then I've been working part time in Gagetown and part time in Saint John.

Q. And the work that you do in Gagetown, you're physically there in Gagetown, are you, working with the

soldiers?

A. Yes. I'm physically here. Now with COVID, sometime I do work from home, but until COVID, yes, I would come here, you know, two to three times a week.

Q. Okay. So the anticipation when the Canadian Armed Forces recruited psychiatrists was that there would be soldiers who would need additional treatment after the Afghanistan mission?

A. Correct. Yes.

Q. What did you anticipate that the nature of your work would be when you were recruited? Was it ... did you think it would involve post-traumatic stress disorder?

A. Yes. So, at that time, I think situation in Afghanistan was very difficult and we were anticipating that my workload will involve predominantly PTSD-related patients.

Q. All right. And your CV says that since that time you've worked with patients with various psychiatric disorders, predominantly PTSD, anxiety and depressive disorders. Would those be the broad categories of conditions that you would see most often?

A. Yes. So in Canadian Forces, in the clinic here, when I join, first several years when Afghanistan-related patients

were predominantly coming for help, I would say, you know, majority of my practice would involve PTSD. But as Afghanistan mission is over and now it's more mixture of various ... so PTSD might have reduced in terms of percentage of people I see. So now I will see any psychiatric disorder that might be present in soldiers, so various anxiety, depression, personality disorder, a few with psychosis. It's now much more varied last few years compared to, say, 2007 until, you know, first several years. It was predominantly PTSD.

Q. How many years would you say that it was predominantly PTSD you were seeing?

A. I would roughly say maybe 2015/'16 until we were getting kind of more and more patients coming forward for help with PTSD.

Q. All right. The ... would you say that you have an expertise in treating post-traumatic stress disorder?

A. I mean I certainly have, you know, experienced and seen many PTSD patients. At one time, I was only psychiatrist in the clinic, so that time I was seeing everybody who was coming here. Now, we have, you know, few psychiatrists. So, yes, I would say over last 13 years, since 2007, I've seen many patients with PTSD.

Q. All right. And in the category in your *CV* under "Other Research Experience", there are two studies or research experiences you've had that seem to particularly relate to PTSD. That would be numbers eight and nine, "Combat-Related PTSD, Examining Outcome in Multidisciplinary Care Setting". That was in 2010. And a "Retrospective Review of a Four-Year Period Prevalent to That Versus Psychological and Health Outcomes Associated with Stress of Military Operation". That was in 2007. Those were both studies that you worked on that related primarily to occupational stress in the military or post-traumatic stress disorder?

(09:50)

A. Yes. So myself and a couple of my colleagues here we looked at, you know, various PTSD patients who are coming to us and outcome and ... one was a retrospective study and one was a kind of outcome in a prospective study.

Q. All right. And in your *CV* you talk about, I guess under "Other Experience", training in CBT, CPT, prolonged exposure psychotherapy for PTSD. So I understand "CBT" is cognitive behavioural therapy, is it?

A. Correct, yes.

Q. And "CPT" is cognitive processing therapy? Is that

correct?

A. Cognitive processing therapy. Yes.

Q. Right. So you have you engaged in those three forms of treatment or work with patients with post-traumatic stress disorder or that's ...

A. So although I have training, I might have seen very few patients for therapy because we work here as a multidisciplinary team. So as a psychiatrist, my role is kind of to complement with our ... so we have psychologist, a social worker, other clinician regarding therapy. So because we work together, my role is more migrated to diagnosis, medication management, follow-up. And my colleagues would get to do more therapy. So that way I can see more patients who are coming through and my colleagues who are seeing therapy will focus on, you know, more therapy using these approaches. But I'm familiar with these approaches for therapy.

Q. All right. And tomorrow we're hearing from Dr. Rogers and I take it, as a psychologist, she would have engaged in those forms of treatment with a number of the patients that you saw?

A. Yes. So Dr. Rogers and me were colleagues were for several years until her retirement. And so she would have been

one of the psychologists in our clinic who I would be working collegially towards ... you know, like a multidisciplinary team.

Q. All right. So just on that point, when you began to work in Gagetown with the Canadian Armed Forces, you said you were the only psychiatrist there initially?

A. So when I join first, there was a psychiatrist who was there who was ... who can ... oriented me to various subtleties of military life and military mental health services because I am civilian. So when I join, 2007, first two, three months, he kind of oriented me to various aspects of military mental health specifics. And then he left the clinic, so then until they recruited another psychiatrist, I was there for ... I was there alone for a long period of time.

Q. And you're, I take it, not the only ...

A. I mean I don't remember exactly when ... what's that?

Q. Sorry. I was just going to ask you, based on what you've said, you're not the only psychiatrist there now, are you?

A. No, no. For last several years, we have at least three psychiatrists and another part-time psychiatrist. So we have enough ... like we have a number of psychiatrists in the clinic.

Q. You say there are three now?

A. Yes. So three ... myself, two other ... (inaudible - poor audio) ... is a military psychiatrist. One is a civilian psychiatrist. And then there's another psychiatrist who comes predominantly for francophone members.

Q. Okay. You just broke up there a little bit, so I'm just going to ask you to repeat that. You said it was a military psychiatrist and a civilian psychiatrist?

A. So right now, in addition to me, there's a full-time military psychiatrist, there's a full-time civilian psychiatrist, and there's a part-time psychiatrist who comes to see francophone soldiers.

Q. Okay. What's the difference between a military psychiatrist and a civilian psychiatrist? Just ... you mean they're employed by the military; one, and the other is a civilian psychiatrist?

A. Yes. So my colleague military psychiatrist is a major. He's only rank of major, so he's an active soldier. He wears uniform versus me and my colleague, we are civilian. We are working as a contractor for the mental health clinic and same with the other part-time psychiatrist.

Q. All right. And you said it's a multidisciplinary

team. What other members are there in the multidisciplinary team?

A. So, generally, mental health services are kind of divided into mental health and psychosocial. And so in mental health, we will have ... in addition to psychiatrist, we will have a psychologist, social workers, mental health nurses, addiction counsellors. In psychosocial team, we'll have nurses, social workers. So that way we can complement that we have.

Q. Typically, when you're treating a patient in the Canadian Armed Forces, is there one member of that team ... that multidisciplinary team that coordinates the care or kind of manages it?

A. So the first kind of entry point would be the family physician equivalent in the Canadian Forces. The acronym is GDMO. So it's a primary care physician who is working for the military. So they will be first person to refer the patient to Mental Health. And then depending on the prevalent issue, it could be either psychiatrist or a psychologist or if addictions are the predominant issue, then maybe addiction counsellor might be the primary treatment provider. And other people might be joining in as needed. So it will be mixture of psychiatrists and psychologists and our social worker who will be following

the patient.

Q. Okay. So it's dependent on the nature of the need of the patient? Is that what I understand?

A. Correct. Yes.

Q. Okay. And the referral process, you used an acronym there. What was it, GD-something?

A. GDMO. It's basically the primary care physicians at the base hospital. So each member will have, depending on where they work, they will have a medical officer who is looking after their physical health issues. So a member could present to the primary care physician and if a psychiatric condition is identified, then they could be referred to mental health clinic for assessment and treatment. So that's how the referral will come to Mental Health Services.

Q. Are there other ways that a soldier can be referred to Mental Health Services?

A. So other ways that if members are in crisis, they can go ... they can self present, it's kind of walk-in, so there's a staff who is at the base medical clinic by rotation. And if they're in distress, they could present themself to the base clinic and the staff, usually a nurse or social worker will assess the patient and if they feel that person needs further

assessment or treatment, they could, in consultation with the primary care physician, refer the patient to see Mental Health.

The other way to go would be member might self identify and present to psychosocial team with a particular request. Like they might be interested in anger management or couples counselling or stress management. And that if the clinician identifies that this person needs psychiatric or psychological assessment, they could arrange for referral to be made to us.

Q. And you mentioned the psychosocial team. And what is that comprised of?

A. So psychosocial team is a group of clinician that ... in our clinic who will be predominantly dealing with short-term intervention; for example, stress management, workplace-related issues, couples counselling. Some might be involved in anger-management-related issues. Some might be ... if member has any concern about, you know, their posting or their family situation, then ... so predominantly related to psychosocial aspects and they can ... typically, they will see them for short term or if ... either member improves or if the member require further mental health involvement, they might be referred to Mental Health Services.

Q. If a member of the Canadian Armed Forces may be having

a family situation, marital problems, there is counseling available for that, is there?

(10:00)

A. Yes.

Q. Are members of your team more broadly trained at all to identify issues of domestic violence or to treat those?

A. I think so. I think, you know, most of the members are experienced and experienced clinicians, so I think domestic violence is probably, you know, is one of the things they might have come across during their working career.

Q. Okay. Is it typical for the team to see a member's spouse or to work with them together or is it typically the member themselves?

A. So when a member comes, we always welcome the spouse or significant family member to be involved, but it becomes member's preference. So some members sometime want their spouses to be involved and many time I have patients who will bring their spouse to every appointment, and some members are extremely private and they do not want their spouses to be involved. So they are ... so we have to respect their wish.

Sometimes family members might come for some appointments and they will not come to every appointment so it varies. But

certainly, it's driven by a member's request and consent but periodically, yes, every family member can be involved.

Q. If a member presents with some psychological issues and doesn't specifically raise their family situation, is that something that treating professionals will sometimes ask them about or regularly ask them about?

A. So it's really part of the assessment process that you will inquire about their current family situation, their family of origin issues, their current family relationship issues. In ... different specialty might handle or manage it differently, but certainly, it will be part of the assessment process, or if members bring it to us like, member wants to talk about it, certainly, it will be explored further.

Q. Okay. When a member is referred to your team for treatment, obviously the length of time that a member is treated is probably largely contingent on what their course of treatment is and what their condition is, but can you say anything about how long you would normally see a soldier who is referred to you?

A. So there's no kind of upper limit in terms of a ceiling. So sometime some members will have very transient psychiatric problem, so they might start to respond within a few

weeks, a few months. And if they settle down quickly, then you might discharge them back to care of their family physician.

Some members might have longstanding involvement and some members might be seen until they're released from the Canadian Forces because they just need that long-term, ongoing support.

Q. For members who you are continuing to see right up to the point in time that they're released from the Canadian Armed Forces, what can you tell us about the process of transition from your care to care after they leave the CAF?

A. So particularly what happens is that when a member is first diagnosed with mental health issues, their family doctor or GDMO, primary care physician, would place them on what is called "temporary category". So temporary category is a six-month provision where a member is given some relaxation in terms of their work expectation, work requirement, work duties, to focus on, you know, helping themselves, like, taking care of their own mental health.

So assumption there is that members are going to recover and they're going to go back to their full duty. So this temporary category is of six months' period and they will extend it by another six months, and in some occasion, even by a third six months, but within a year or a year and a half, it becomes

apparent that member is not able to get back to full duty as a soldier, then this member will be placed by the primary care physician on what is called "permanent category".

So permanent category is kind of, then their paperwork is sent to Ottawa to a group that looks at their file, their whole file and situation and determines whether they need to be on permanent category. And if they determine that this person needs ... is unable to meet the expectation of their work, then this person might be getting a medical release process.

So once we know that someone is getting medically released then the transitioning starts. And there are various agencies or various people involved in transition planning.

So from a mental health point of view, if they have .... if a member has a VAC ... Veterans Affair entitlement for their mental health issues, then, typically, this person will be referred to OSI clinic, operational stress injury clinic, in Fredericton for continuity of care.

So usually I will start making the referral a few months before their release. We take members' concerns and then we send all the documents to the OSI clinic in Fredericton usually. And then as ... then one of the staff from OSI clinic will usually contact the member and do the intake assessment and get

that in the system.

So I will continue to follow on my ... you know, we will continue to follow member until their day of release and then the OSI clinic takes over the responsibility.

If member has any family doctor that they have identified that they are able to get on family physician's list in the community, then we'll send the referral and their documents to family doctor as well.

If any member doesn't have a family doctor at the time of their release, then if they get connected with a family doctor and if they sign consent and ask for paper ... their mental health documents to be transferred, then we'll do so.

Q. So many of the soldiers ...

A. So this is from the mental health side of things, but there are other agencies or other group of people like case manager who will also be involved in preparing member for transition.

Q. So many soldiers do transition to the OSI clinic in Fredericton?

A. Yes. I mean it's a very common kind of process to refer releasing member to OSI clinic in Fredericton. If any member who's leaving who doesn't have Veterans Affair

entitlement, then we might refer them to community mental health clinic in Fredericton or nearest clinic in their ... where they are going to relocate after their release.

Q. Is that the VAC case manager that would typically make those arrangements or determine where the soldier should go for treatment?

A. So we will typically refer to OSI clinic in Fredericton for people who have Veterans Affair entitlement and we have case manager here for the ... in our clinic. So I think, between the case manager and mental health nurses, they will liaise with the OSI clinic in terms of referring people to appropriate agency for follow-up.

Q. Okay. And you said a moment ago that a member who wants their file and signs a ... or wants their file to be transferred to another doctor and signs a consent, that will happen, that you will release the file to that doctor?

A. Yes, yes.

Q. Short of that, I guess, short of the member actually signing a consent and saying, I want you to send my file to Dr. so-and-so, that may not happen automatically?

A. If member doesn't know where he's going or he doesn't have a designated clinician, then it's ... then we will not send

it to any specific person. But members also have a capacity to go to medical record before they get released and get copies of their medical record printed out so they can have their own kind of copy with them to take it to their, you know, next clinician who is providing care for them.

Q. And I'm sorry, you said the soldiers have the ability to go to whom to have their medical file printed off?

A. There's a medical record division or medical record department, so they can go to medical record and get a printout of their (inaudible - audio quality) ...

(10:10)

Q. Is that something that ... sorry?

A. ... documents and ...

Q. I'm sorry. Is that something that happens automatically or is that something that the member has to go and take the initiative?

A. Sorry (inaudible - audio quality).

Q. I was asking about ...

A. So as they are leaving, as members ... so as members are leaving, there are multiple tasks a member who is leaving has to do. So one of the tasks would involve going to medical record and collecting or asking for their records. So case

manager will usually help them to prepare and understand what they need to do and make sure or, you know, make them aware of various aspects of release (inaudible - audio quality).

Q. Sorry. I don't mean to go over the same ground, Doctor, just you broke up and I think I was breaking up a bit as well. So I just want to understand.

A member has to go and do that, to ask the medical records division for their medical file? It's not something that's given to them automatically, is that correct?

A. No, because it probably involves consent, so they need to ... member needs to go and ask for their records. So they will be made aware about their sources or who to go to contact.

Q. Okay. Do you typically consult with or liaise with a doctor that will be treating a member after they leave the CAF, say, at the OSI clinic?

Did we break up? Are you able to hear me? Lose him? Freezing up.

THE COURT: Yeah, I think we've broken up. All right, thank you. We'll just ... we'll recess till we re-establish this connection here.

A. Hello?

THE COURT: Thank you.

A. Hello?

MR. MURRAY: Hello, Doctor. We're just going to take a break and get our connection again.

THE COURT: Thank you.

A. Oh, no, I can hear you now.

THE COURT: Dr. Joshi, we're just going to take a short break and check out some of our settings here but, please, just remain on the connection if you could, thank you.

A. Okay, sure.

COURT RECESSED (10:12 hrs.)

COURT RESUMED (10:51 hrs.)

THE COURT: Thank you, Dr. Joshi, for waiting patiently. Appreciate it.

A. Thank you.

THE COURT: Mr. Murray?

MR. MURRAY: Thank you, Your Honour. Thank you, Dr. Joshi. Just before we broke I was asking you, and you were telling us about, the process when soldiers are leaving the Canadian Armed Forces and how they transition, I guess, to their post-CAF care.

Do you see any issues there? Or in particular with respect to soldiers finding care when they leave the military, accessing

their records, and the general communication between, say, yourself and physicians after a member leaves? Are there issues there, things that could be improved?

A. So generally, I think the process works well. I mean we ... every month there are a number of members who get released. So it has developed into a relatively well-established process. So I think by and large it works, but again, there might be occasional exception where things might miss. And that sometime happens when member is not sure about their Veterans Affair entitlement. Sometime a member might have thought ahead a release date but for some reason they might decide to leave early. So then we might have to call them in OSI clinic and say, This member is actually leaving early and can you take them or can you see the person early?

So generally, my experience, it works well, but there could be exception where it may not have worked well.

Q. And the doctors at the OSI clinic in Fredericton, I take it you would have had occasion to speak to the treating professionals at that clinic?

A. So normally when I refer releasing member to OSI clinic it's usually done three to four months in advance. So at the time of referral I do not know which doctor or which

clinicians are going to be involved in OSI clinic, who the member's care is assigned to. So I will continue to see the member until their day of release and then the member will be transferred to their first appointment with their other treating doctors.

So usually it's either paper file or the records being sent. There are some situations where you are really concerned about member or you want to make sure that you have to make that contact. So there are occasions where I would call the doctor and say, This is the member coming, and may discuss their issue. Sometime our nurses or other staff might call the OSI intake worker, but generally, at the time of referral I would not know who the member is getting assigned to.

Q. Okay. So if we could turn to Cpl. Desmond and your treatment of him. There are a number of documents that we've been provided that record the nature of your care for Lionel Desmond. It seems like you saw him first in 2011, and I'm going to refer you to an exhibit which we've marked as Exhibit 183. It's a psychiatric assessment from September 28th, 2011. You're familiar with that document, are you?

A. Yes.

EXHIBIT P-000183 - PSYCHIATRIC ASSESSMENT OF SEPTEMBER 28, 2011

Q. Okay. Was this in or around the time that you first saw Lionel Desmond?

A. The document is not up yet here. Yes, this is the ... this is the first time I would have seen Lionel Desmond on 28th of September 2011.

Q. Okay, and the document, the psychiatric assessment you would have prepared shortly after seeing him. Is that correct?

A. So typically, I would see the member and then after ... as soon as I'm done I will dictate my notes and then my admin staff will type it and it will be submitted to medical record like electronic database for entering into the system.

Q. Okay, so this would have been entered into the electronic database that other medical records would be entered into?

A. Correct, yes.

Q. And that database is what? What is called?

A. It's CFHIS. So it's Canadian Forces electronic medical record. I don't remember exact acronym, but it's been electronic database that has physical health or mental health, psychosocial case management. So essentially all aspects of care of the member is in the same database.

Q. Okay. So any documents that you would have produced

related to your care or treatment of Lionel Desmond would have been entered into that system, would they?

A. Yes.

Q. Okay. The document indicates that there was a referring physician. That's a Cpt. MacDonald. That would have been a family doctor for Lionel Desmond, would it?

A. Yes. So Cpt. MacDonald at that time was family doctor who would have seen Lionel Desmond and then he would have referred Cpl. Desmond to see me. So he would be the referring physician.

Q. Your letter says: "Thank you for referring Cpl. Lionel Desmond for psychiatric assessment." How much information would you have had when Lionel Desmond was initially referred to you? Would you have had any sense of what the reason was for the referral?

A. Yeah, so in the referring note the attending physician would write, you know, the concern or reason for referral and I would have ability to access Cpl. Desmond's chart. So I would have information of the referral ... reason for referral.

Q. Okay. So the documents that you would have had access to, those would have been on CFHIS, would they?

A. Yes.

Q. Okay. And would you typically have occasion to look at those in any detail before you meet the patient?

A. So typically, I would go through the document. You know, sometime I would see the documents afterward. Sometime you want to have as much information as possible when you start seeing the patient but some other time you might take the important information and then check it out later for any other detailed information you might need.

Q. Okay. And in terms of the member's history, beyond the medical history, just the nature of their deployment or their work with the CAF, how much of that would you know about when the member first walks through the door?

A. So if the information is available in the medical chart we can read that. If their personnel file needs to be seen we can ask for that. So if required we can access it.

(11:00)

Q. And would you typically do that, or would it depend on the nature of the member's presentation?

A. It will depend on the nature of presentation. So if there are concern or any inconsistency in the information that is provided I want to check it out, something for validity then you could ask that. But many times it may not be needed because you

may not have reason to access it.

Q. Okay. So you have a bit of a history of his work with the CAF in the letter. Would that have been obtained, do you recall, from Lionel Desmond or from his file or both or can you say now?

A. Both. I mean I would ask these question to the member and check it out with the CFHIS to just be sure.

Q. Would Lionel Desmond have had a diagnosis or a tentative diagnosis when he came to you or would that be something you would do?

A. So diagnosis is something I would do. So that would be based on my assessment or definitely diagnosis might be established.

Q. To your knowledge, had he seen another psychiatrist or another mental health professional in CAF prior to seeing you?

A. I'm not sure of that. I mean I don't recall that or whether he'd seen somebody or not.

Q. Okay. Can you give us a sense, the first time that you meet him, how long you would have spent with him and what the nature of the interaction would be? Is it a discussion, a Q and A? How does that work?

A. So typically, first session is booked about hour 15 to

hour and a half. So you would spend anywhere from 50 minutes to an hour 15 minutes in kind of establishing the history, and then about 15 minutes for dictation of my notes.

So generally, in psychiatric history we will start with open-ended questions. So we give the member a chance to tell their story and after, say, about 10, 15 minutes we would start to have more kind of focussed interaction, focussed questioning that would help elicit various symptomology, family history, personal nature, those nature.

So it will kind of progress in that manner for, you know, first 45, 50 minutes and then last ten minutes might be giving feedback to the member, diagnosis, treatment plan. So that might be a typical interaction during the first assessment.

Q. I appreciate this was ten years ago but do you recall if Lionel Desmond was forthcoming with you about his situation and his symptoms?

A. He was forthcoming. I mean he told me a lot about his trauma in Afghanistan. He told me a lot about his situation and he came across as a honest person. He was anxious but he was ... he participated fully in the session.

Q. You said in your letter that he had told you that he was not feeling well for the last three to four years. Or three

and a half to four years.

A. Mm-hmm.

Q. Did you explore or do you recall why he may not have been referred to a mental health professional before that or why he hadn't accessed that help?

A. I mean this is not unusual presentation that many time members will try to manage their symptoms on their own or they might not have insight to seek help. Or sometime members might want to protect their career. They are nervous about seeking mental help.

So a lot of times it is fairly common that member person might be going through slow changes in their personality and their behaviour. So he certainly had symptoms for a while and he decided to seek help at the persuasion of his wife.

Q. That was your recollection, that it was his wife that prompted him to seek help?

A. Yes.

Q. There are a number of symptoms that are disclosed in the letter. What do you recall ... I guess I'll ask you, what was your impression of him when you first began to speak with him?

A. So, again, I'm speaking from my memory approximately

ten years back, but he was extremely distressed and anxious and he had difficulty with sleep. He was experiencing a lot of nightmares. He was not able to go out of house. He was concerned about dealing with the anger, kind of feeling emotional numbness. So he had been thinking and reliving some of the experiences from Afghanistan.

So he was ... my opinion was he was quite symptomatic at the time of initial presentation and he had very limited insight or understanding as to what was happening.

Q. And the symptoms that he was exhibiting, what were they ... in your opinion, what were they symptoms of?

A. So these symptoms collectively will be part of PTSD or post-traumatic stress disorder.

Q. And I'll ask you about your diagnosis of him in a moment. But was that the primary thing that you saw, the primary condition that you felt he was suffering from?

A. Yes. So he had various symptoms of ... he had history of exposure to multiple trauma during his deployment. He had intrusive thoughts related to those trauma. He had nightmares. He had flashbacks about the incident, intense anxiety, difficulty to interact with friends and family, isolating himself.

So those are kind of cluster of symptoms that would be for a

PTSD person ... a person suffering from PTSD.

Q. Are those ... would you say those are the most common symptoms of post-traumatic stress disorder?

A. Yes, I would say so.

Q. Were there any that he was not exhibiting that you might have expected him to?

A. No, I don't think I recall any major ... I mean he was meeting the criteria. I don't think I recall any unusual presentation of his symptoms.

Q. Okay. He ... you talked to him about his marital situation a little bit. I think you said he feels their relationship - that is he and his wife - may be heading toward separation. Do you recall if that's something that he brought up or something that you drew out of him?

A. I think it's a combination of both. So when I was ... I would have ask him about his current living arrangement and he would have told me that he was living alone and then further explanation of that, he informed that his wife was trying to ... she was studying to become a nurse and was living in Nova Scotia and he was living alone and he was concerned about their relationship not in the best terms and was worried about ... you know, worried about how ... where it was heading and especially

worried about financial situation as well. I think he had to co-sign a loan for a student loan and he was thinking if he made a mistake or he ... if the relationship goes toward separation, then he would have taken the responsibility for the loan, the student loan.

So some of the information I would have asked him and some of it he would have disclosed to me.

Q. It may be difficult to say to what extent their marital situation was affected by his post-traumatic stress disorder and how much by other factors. Were you able to make an assessment of that?

A. No, I think it's probably combination of multiple factor, but certainly, his diagnosis, the long-term ... like the separation due to her studies could have been factors.

Q. You had said in your letter that ... and I assume this is something that you asked, but you can tell us, that Lionel Desmond denied violent thoughts but admitted to experiencing suicidal ideation, however, he had no suicidal plans. Is that an area of exploration that you would typically review with a member?

A. So ... yes, so assessing suicidal ideation and assessing potential for violence is one of the part of

psychiatric assessment. So there are a number of ways we would ask those questions and try to clarify if that person has ... intends suicidal ideas, a plan, if there's any imminence to the plan, and same with the violent thoughts towards any family members, friends, or any other people.

(11:10)

So exploring suicidal ideation and violence thought is a fairly common kind of ... you know, standard practice.

Q. What types of questions would you ask a patient to draw that information out?

A. So typically, the questions would ... for example, for suicidal ideation, the first questions would be, you know, How is your mood, how are you feeling, are you getting any thoughts that you wish you're not here? Or the more explicit part of the questions including, Are you having any suicidal ideas, you know, plans, what would you do to accomplish those plan? What about ... whether you've written any suicide notes or trying to dispose of your personal belonging.

You can also assess for any protective factors, which would include, What would hold you back from acting on your impulse? And this typically might ... member might say for their family or children or religious reason that they might hold back from

acting on their impulse. You can also explore how feasible is the plan, whether there's any imminence, like person is likely to do in an imminent manner, act on suicidal plans.

So these are some of the questions that you would ask about suicidal ideation. Similarly, violent thoughts and plan. Well, you could start something like, Are you getting any angry thoughts, are you getting irritable, moody? You would then explore if you're getting thoughts about hurting somebody and then you'll explore more in detail if there's any specific plan, if this person is, you know, at imminent risk and it's realistic that someone could act on those plan and what's holding back or what's protecting factor.

So these are some of the questions that you would ask in suicide and violence risk assessment. Even more like a conversational manner so you can integrate it into your assessment. So I mean psychiatrists, we're going to try to act as a scripted kind of format, like five questions, one after the other. But it's more like a conversational approach where you would move from one topic to another topic and in that you will explore certain areas that you want to highlight or you want to make sure.

Q. Okay, so it's sort of ... it's organic, I guess, in

that it flows through the conversation with the patient?

A. Yes, true.

Q. Do you have ... do you typically use a checklist or a tool to assess for suicidal ideation or plan?

A. So typically, what happens is that when the member first comes in they fill in certain questionnaire. Those questionnaires are for PTSD, for anxiety, depression, and so before you start seeing the person you'll go through that. So that checklist is ... so you know what areas to highlight. But then once I'm interviewing someone I will not go through those checklists with them because I'll have that information.

Because sometime person feels it's very scripted. So rather than ask the person's agenda of what they want to discuss in the session, it becomes more like doctor's agenda of wanting to ask all the questions. So it more flows in a conversational manner.

Q. When you saw Lionel Desmond first - a couple of other questions about his presentation - you said that he did not endorse any symptoms suggestive of mania, hypomania, psychosis, OCD, or anxiety disorder. When I asked you in particular about psychosis later on treating professionals have seen some paranoia exhibited by Lionel Desmond. Did you see any of that early on when you first saw him in 2011?

A. No. So throughout my involvement with him I never saw symptoms suggestive of psychosis. So no, I didn't see any symptoms suggestive of psychosis.

Q. Even setting aside a full-on diagnosis of psychosis, did you see any paranoia, in particular when he was discussing with his relationship with his wife?

A. No. I think his concerns seemed so realistic and did not seem like they were unfounded or unrealistic. He wanted to have a relationship with his wife on an ongoing basis but he was worried that she might not be fully committed to the relationship. So he was worrying that she might leave him but it didn't seem like it was delusional or psychotic in nature.

Q. All right. And at that time you saw him you saw no evidence and he reported no evidence of head injury or neurological symptoms at that time?

A. No. So he denied any history of head injury. He denied any exposure to any blast injuries. There was no history of any loss of consciousness, seizure, any double vision, any neurological symptoms. So he denied that and so there was no kind of reason that he disclosed to concern about head injury.

Q. What was his status with the Canadian Armed Forces when you first saw him in terms of his duties?

A. So at that time he was working band in RCR.

Q. Yes.

A. So when I saw him he was already working there for his unit.

Q. That was the pipe and drum band, was it?

A. Correct. Yes, yes.

Q. Did you have any thoughts at that time whether that was appropriate for him or did he say anything about that?

A. I mean he was already in working in the band. So it was kind of already established place of work. He was not happy but he wasn't kind of resisting or protesting a lot about it either. So he was kind of accepting with some unhappiness I would say.

Q. Were you aware whether there were restrictions on his ability to perform certain functions in the CAF when you first met him?

A. So I was not aware, but typically, he would be on what is called temporary category and restrictions but I don't recall whether he was at the time or not.

Q. All right. You were able to make a diagnosis or a couple of diagnoses, I guess, of him.

A. Yes.

Q. So you diagnosed him first with post-traumatic stress disorder with major depressive episode operational.

A. Yes.

Q. So what was it ... and, again, you've talked about the symptoms but what was it that was required, I guess, for you to feel that it was appropriate to diagnose him with post-traumatic stress disorder? What did you see that would support that diagnosis?

A. So he had experienced multiple trauma in his deployment and then he was experiencing intrusive thoughts, memories, dreams about those incident. He had a lot of avoidance symptoms. He was feeling emotional numbness. He had some flashbacks of those experiences. So these are all criteria to diagnose post-traumatic stress disorder.

He had generally low mood, sadness, guilt feeling, not able to enjoy life, and some of the other depressive symptoms. So he kind of met diagnostic criteria for major depressive episode as well.

Q. So the ... I think you had said to us earlier, if I recall, that typically for the PTSD diagnosis you need a traumatic or tragic event followed by a cluster of symptoms.

A. Mm-hmm.

Q. Do I have that correct?

A. Yes.

Q. Okay. And that was his presentation then, was it?

A. Yes, yes.

Q. The major depressive episode operational, what does it mean when you say it was operational?

A. So it's basically applicable for both diagnosis, PTSD and major depressive episode. So it's kind of connected to the deployment-related experiences. So operational is a contact would be used for indicating that it was part of the deployment related-issues. So, for example, one could see PTSD patient and that member might have, as a civilian, like childhood sexual abuse or ... which do not involve overseas deployment. So in that case it will be called non-operational PTSD or major depression.

Q. Okay. Now I assume at that time you had seen a number of members with post-traumatic stress disorder.

A. Mm-hmm.

Q. Can you give us a sense how his condition compared to others you had seen in terms of severity?

(11:20)

A. So at that time he was kind of moderate to severe in

range. So he was extremely symptomatic at the time and the most difficult part was that he had very limited insight about what PTSD was. So he was, I would say, moderate to severe category.

Q. The ...

A. And probably comparable to many other members I would have seen with similar diagnosis.

Q. You would have seen other soldiers with a similar severity of PTSD at that time?

A. Yes.

Q. You also note in your diagnosis marital difficulties and separation from family. This was also part of what was troubling him at the time, was it?

A. So this was part of the psychosocial stressors that he was experiencing at that time. His wife was in Nova Scotia and he was here and so that was part of kind of social isolation so to speak along in the background of marital difficulties.

Q. That social isolation, I take it that was a problem for a number of members, was it, who were dealing with a condition like PTSD?

A. Yes, I think part of PTSD symptoms are avoidance. So members with PTSD tend to avoid interacting with other people, friends, family, avoid hobbies, interest. A lot of members will

get intense anxiety in social situation like family get-together, workplace get-togethers, or going to malls, et cetera. So a person start to get more withdrawn and more isolated from various activities that they could enjoy or participate.

Q. After you met with him and made your assessment of his condition then I take it you developed a treatment plan? You have a section of the letter that refers to management.

A. Yes.

Q. That's something that you would discuss with the member and determine how best to proceed?

A. Yes. So probably the management would involve giving some feedback of the session based on what we discussed and then ... so at that time I gave him some information about PTSD, gave him some information booklets about explaining the diagnosis and he was started on ... he was already on some medication. So I increased the dose of the medication to more therapeutic dose, discussed, probably, with him about the role of medication and potential benefits and side effects, et cetera, and he was referred for trauma-focussed therapy as well as a psychoeducational group that we were running at that time. And then I had made arrangement for followup in a week's time.

Q. Right. So you said he had limited understanding of his

condition. Did he know at the time what post-traumatic stress disorder even was?

A. No, he didn't, and that's why he was given some information during the session, as well as he was given some information to read and he was referred to see a psychoeducational group that we had for PTSD members.

Q. Okay. Now you said he was on some medication and your letter says that you increased Effexor from 112.5 milligrams a week to 150 milligrams. What is ...

A. Correct, yes.

Q. What is Effexor? What is the purpose of that medication?

A. So Effexor is an anti-depressant medication that works on a couple of neurotransmitters in the brain. It helps with depression/anxiety symptoms. So it's therapeutic doses. 75 is kind of the lower end of the dose and it can go up to 300 milligram. So I had increased it to more middle-of-the-range dose to get him more effectiveness with the treatment or improve efficacy.

Q. And you started him on other medication. Risperdal, one milligram a day. What is that medication and what is it for?

A. So risperdal is a typical anti-psychotic medication.

It is used at a lower dose to ... not because he was psychotic, but it's used at a lower dose to help with anger, irritability, mood swings. And ... because he was constantly thinking about events from Afghanistan.

So sometime or many time he ended up using combination of medication. Prazosin is a medication that helps with nightmares. It's actually a blood pressure ... it's used for blood pressure management but at a lower dose it helps with nightmares. So it was given along with the other medication to help with the zopiclone to help him with sleep, because he was not able to sleep well and was having regular nightmares.

Q. Those three medications, risperdal, prazosin, and zopiclone, those are typical medications prescribed for people with PTSD?

A. Yes.

Q. Right. Now you said that he was referred for trauma-focussed therapy. What is trauma-focussed therapy? Can you explain that to us?

A. So trauma-focussed therapy is a kind of ... it's a broad category that, essentially, encompass a number of treatment approaches to help patients with PTSD. So it kind of came from cognitive behaviour therapy. So idea is to expose the patient

with PTSD to various intensity of their trauma that they might have experienced in a controlled manner by the therapist and exposure over a period of time helps to reduce the emotional intensity of the trauma.

So sometime instead of being specific about what kind of psychotherapy a person should have, it's more like broad-based recommendation and the details of the ... what therapy approach need to be used are left to the therapist and the member because some members might respond to one particular type of trauma therapy while others might respond to the other one. So it's a kind of broad category to say that this member needs PTSD psychotherapy.

And would it be a psychologist that would engage in the trauma-focussed therapy with the patient?

A. So it will be either psychologist or social worker or a nurse who might have appropriate training to do trauma therapy. So they had to have ... so trauma-focussed therapy is generally done by some of these specialty of their training. But in Cpl. Desmond's case, it was Dr. Wendy Rogers, who is a psychologist, very senior psychologist in our clinic. She was assigned to do a trauma-focussed therapy.

Q. Right. And also he was referred to a psychoeducational

group.

A. Yes.

Q. What would that look like and what would the purpose of that be?

A. So psychoeducational group was over four to five sessions. It would involve having anywhere from five to seven members. I don't know exactly how many took part in his group, but essentially, it was spread over four weeks, a couple of hours, where details of PTSD, its various symptoms, its triggers, managing some of the triggers, various treatment as available.

So some of these educational complement of treatment will be provided and it was run by a couple of colleagues in our clinic. And I think Cpl. Desmond must have participated in that psychoeducational group. So it kind of prepares the member to start more intensive psychotherapy with the psychologist, so based after some sort of background knowledge and information as they're prepared to enter into more intensive therapy.

Q. Each of these parts of the treatment plan, the pharmaceutical, psychological trauma-focussed therapy and so forth, those were, I take it, all standard treatments for soldiers with PTSD at the time?

A. Yes.

Q. Did you have a sense, having met Lionel Desmond and creating the management or treatment plan, what his prognosis was at the time?

A. No. I think the prognosis was not happened immediately because many times many members would improve with treatment. Some members might improve significantly but they're not able to work in the military or it would not be advisable to work in military because you don't want to re-traumatize with a different kind of deployment.

(11:30)

So at initial time, the prognosis would have been guarded or one wouldn't speculate on prognosis at that time. Certain factors can help over a long period of time which would include things like family history of mental illness, early life childhood experiences, social support, substance use, insight and compliance of treatment so ... But those factors will help over time to kind of make a judgment about long-term prognosis.

Q. It was difficult then, I take it, to make any predictions about how long the course of treatment would be?

A. That's correct, yes.

Q. Okay.

A. Many times, member when they start therapy someone who

is going through PTSD, sometime during therapy session they start remembering other traumatic incident that might have happened that they might have forgotten, or other issue starts to come in that were not manifesting at the initial presentation. So treatment duration is different or varied at the time of initial assessment.

Q. The plan going forward, you were intending to see Lionel Desmond again on a regular basis, were you?

A. Yes. So initially I would plan to ... or I would have seen him regularly every two to three weeks. I think the first appointment I asked him to come back in a week's time.

So initially my role would be to continue assessing him, continue to provide education about PTSD, make sure he's taking medication, address any concerns he might have about side effects or any question that he might raise and prepare him so that he can start entering into therapy.

Once he got established into therapy then the therapist would see the member frequently, usually once a week or once every two weeks, and they will be ... So then I might take a little backseat in terms of how frequently I would see. So I might see once a month and the therapist might see the member, you know, two or three times a month for therapy. And the

intensity and frequency of contact, I mean, is if needed or it can be reduced if someone is stable and doing well.

So it can vary from, you know, every couple of weeks to every couple of months depending on stability and frequent compliance.

Q. Initially your intention was to see him, I think, on a more regular basis, is that correct?

A. Yes, that's correct.

Q. Weekly?

A. Weekly to two weekly, depending on, you know, appointment scheduling.

Q. And he was scheduled then to see the psychologist, Dr. Rogers, as well, is that correct?

A. Yes. Yes.

Q. How would the treating therapist be chosen? Was there ... was that dependent on the condition or was it a function of who maybe had the most availability?

A. I mean, so, in the clinic, we would have ... we would be aware about who are the clinicians who are able to treat PTSD patients so ... and then who might have openings available immediately, or immediately in the sense that they can see the member quickly.

So therapists typically will be seeing patients, some of them might be getting discharged so they might create openings for new patients to be seen. If we feel that there are, you know, the clinic therapists are not able to see members in quick time then we can also refer members to a community provider of psychologists and other therapists. So it will be mainly judged by availability and ability or expertise to treat such conditions.

Q. Okay. And Dr. Rogers was an appropriate person to treat Lionel Desmond?

A. Yes. Dr. Rogers was one of the most experienced psychologists at the time and she had a wealth of experience.

EXHIBIT P-000188 - PSYCHIATRY PROGRESS REPORT - OCTOBER 5, 2011

Q. Okay. So going forward you ... I think in the documents there are a number of psychiatry progress reports so perhaps we can just bring one of those up and have a look at it. Exhibit 188, for example. Is this ... I don't know if you have it yet.

A. Yes, I do.

Q. Okay. Is this the type of document that you would normally complete when you would see one of your patients on an ongoing basis?

A. So at the time this was the document that we were using, so that would involve the progress report. And that time ... So some of the headings would be completed and any kind of observation that might be there would be entered in those boxes where you would see. So this would be a typical follow-up progress note that we were using at the time.

Q. Okay. Now this document says that on ... I should say it's dated October 5th, 2011, so this would be roughly a week after you had first seen him.

A. Yes.

Q. And you met with him on this occasion for about 30 minutes.

A. Yes.

Q. Is that about standard for the ongoing visits?

A. So follow-up will be typically 30 minutes. So about 20 to 25 minutes will be conversation and then a few minutes for writing up notes.

Q. Okay. The symptoms that he endorsed on ... the week later, were they similar to what he had described the first time you had met him?

A. Yes. So basically mentioned about sleep disturbance, so he was going to be ... or one of the things ... one of the

topics that he wanted to discuss with me was not sleeping well and he was taking medications regularly and he was reporting that he was less irritable compared to first presentation.

So one would go through some of the initial presentation symptoms, assess the compliance, discuss any issues a member would want to discuss and prepare him to start the therapy.

Q. You had changed ... you had prescribed some new medication on the 28th of September and increased the dosage of one medication he was already on. Is there a period of time you would observe the effects of that medication before you might change the dosage?

A. So typically for antidepressant medication I would wait for four to six weeks. For sleep medication, one of the sleep medications is zopiclone, you would look for benefits over the next few days. But with the medication that helped for nightmares, the dose has to be increased slowly otherwise a person can get side effects. So you have to titrate those up to such a level that it helps with the nightmares but doesn't cause side effects.

Q. Right. So I assume that it would be important to continue to see it ... especially early on, to see a patient to determine how the medication is working and whether it needs to

be changed?

A. Yeah, especially if one has to engage a patient into treatment. Initially, frequent contacts are important so that would kind of help to connect with the person and help establish rapport and, you know, help the member to kind of follow the treatment plan, address any concerns or questions they might have about side effects or what's happening. So, initially, I would see more frequently.

Q. The document that you created on October 5th, 2011, you said: "No SI. No HI." Again, I assume that's suicidal ideation and homicidal ideation?

A. Yes.

Q. Would those topics ... again, on the shorter visit, how would those topics be discussed with him? Would he be asked if he's feeling those thoughts or would it kind of ...

A. So it will be, again, in a conversational manner. So as you are going through the assessment, you would ask something like, Are you having any bad thoughts? How are you feeling about suicidal thoughts that you were having before? If he endorses it then you would explore it further to ask if there's any plan, if there's any change compared to previous presentation. So you would spend, and depending on answers he will elicit, you would

spend some time or a longer time depending on the concern. I mean if you are satisfied that the member is honestly telling what they're feeling then you could move on to another topic of, say, violence.

(11:40)

Q. Are those topics that would be covered in every session or you'd make some judgment about them in every session?

A. So generally, yes, it will be covered in every session, but how you ask question might vary depending on presentation. So, for example, if someone comes and say: I am doing fine, I'm looking forward to going to holiday, and he seems to be optimistic, then you might just ask question and may not explore it further because you're getting the impression that person is futuristic oriented; he is looking forward to something in life. So you moderate your depth of your questioning depending on the responses you are getting.

Q. Okay. Now there are a number of psychiatry progress reports in the documents we received and we'll look at some of these, we won't look at every one of them. But it does appear that he had ups and downs, I guess, is that a fair statement? What's your recollection of his ...

A. Yes.

Q. ... course of ... well, through the course of treatment how he presented?

A. So he ... So I think I saw him in end of September/ beginning of October, so I think first month I think he was significantly symptomatic. In my notes towards end of October he was reporting that he's sleeping better, he's feeling better, more good days than bad days. He started to report that he was finding therapy helpful.

And then I think towards spring of 2012, he again started to notice significant worsening of symptoms. He was having a lot of nightmares, anxiety, and he was not functioning well. So his course kind of fluctuated between having periods where things were going relatively better versus, you know, worsening of symptoms.

Q. Was that normal for a patient with post-traumatic stress disorder?

A. It (inaudible - audio) ...

Q. We froze.

THE COURT: I wonder if Dr. Joshi can hear you.

MR. MURRAY: Are you able to hear me, Dr. Joshi? He sort of stopped in mid-sentence.

THE COURT: Just see if he can ...

A. Hello?

THE COURT: Hello. Dr. Joshi, can you hear us now, sir?

A. Yes, yes, I can hear. Yes.

THE COURT: All right. You froze for a moment and you were just answering a question about whether increase ... I'm going to paraphrase the question was one relating to increase in symptoms, whether it was unusual and we didn't quite hear your answer before you froze.

A. So, typically, the majority of members will have fluctuating course and sometimes it seems like they're making progress and there might be a period of improvement in symptom and then sometimes things might get worse. So he did have a very fluctuating course of response (inaudible - audio).

THE COURT: I didn't hear the last word.

MR. MURRAY: Just at the very end, Doctor, if you can pick it up again.

A. And so he did have fluctuating course of treat- ... fluctuating course of symptoms.

THE COURT: Thank you.

MR. MURRAY: All right. Thank you.

So ... and, you, I think made reference to one of your notes ... and maybe we can bring it up, it's Exhibit 189. I think this

may be the document you were referring to when you said that at the end of October he started to show some improvement?

EXHIBIT P-000189 - PSYCHIATRY PROGRESS REPORT - OCTOBER 27, 2011

A. Yes, 27th of October.

Q. Would that be a function of the medication at that point or are you able to say what might have helped to improve his condition?

A. I think it probably was a function of medication at that point because certainly sleep was improving and he probably started to feel positive about, you know, connecting with myself and Dr. Rogers, so he was probably developing some hope about the treatment and ... Because it was too early for psychotherapy to be effective, but certainly the skill development or skill building might also help him generally. Like, you know, more insight and more understanding about his condition, could also have helped him to understand what was going on and what was the plan.

Q. Would he have started the psychoeducational group at that point?

A. I don't know exact dates but, yes, he would have started towards end of October some of the psychoeducational sessions.

Q. Okay. So I want to bring up another document, this isn't one of yours but I just want to ask you a couple of questions about it. It's Exhibit 219.

EXHIBIT P-000219 - MEDICAL REPORT - JANUARY 27, 2012

So this is a document that at least at the bottom says it was signed by Ms. Janet Weber, NP. I take it ... is that "nurse practitioner"?

A. Yes, Nurse Practitioner Weber, yes.

Q. Okay. So what would the role of the nurse practitioner have been in working with the patient?

A. So nurse practitioner, along with family doctor, they form part of the primary care physicians. So a nurse practitioner got involved in this primary care physician role. I'm not able to read the documents. I don't know if you can expand it a little bit.

Q. Maybe just ... yeah, zoom in at the top.

A. Yes, zoom. Yeah, okay.

Q. So this type of document, there are a number of these in the materials. Would the nurse practitioners, to your knowledge, do regular assessments of the patients and record them, what they see in these documents?

A. Yeah, so member will have a number of appointments with

their primary care physician as well as from the mental health team and so, yes.

Q. So this particular document is dated January 27th, 2012, and it says that Lionel Desmond ... and I'm just looking at the top ... obviously he's in the band and it says on TCAT or temporary category, I understand, for MH.

A. Yes.

Q. That's "mental health" is it?

A. Yes. Yes.

Q. Okay. So at that time the nurse said that he would be followed by Dr. Rogers weekly and by you monthly. So at that point, were you cutting back the visits, I guess, from weekly or bi-weekly to monthly?

A. No, I think it might be kind of averaging out kind of understanding from her. So I would basically, but once Dr. Rogers start to see a member on a weekly basis then my appointments would be reduced to maybe once a month or so. So, in that sense that's accurate, but I don't know exactly the date, whether it happened around that time or not.

Q. Okay. But I guess what I'm asking, going forward the frequency of the visits with you might decrease a bit or be less frequent?

A. Yes. So as he would be getting established on medication and once the dose is established then he would basically would kind of given background to work on his therapy and then Dr. Rogers will be more involved in pursuing or going ahead with the trauma therapy. So that would be ... then her role will become more important in kind of conducting the therapy sessions.

Q. Okay. The medications that were prescribed, they ... obviously as any medication, they could have side effects could they, Dr. Joshi?

A. Yes. Yes. Yes.

Q. Did you or do you recall if Lionel Desmond complained of side effects from any of the medications he was taking?

A. Initially I don't think he complained. Initially, I think he was tolerating the medication well. But at some point towards the end maybe he might have noticed some side effect of tiredness and fatigue or not able to focus I think. But at that time, early in the treatment, he seems to be tolerating it well.

(11:50)

EXHIBIT P-000220 - PSYCHOLOGY PROGRESS REPORT OF DR. W. ROGERS - FEBRUARY 9, 2012

Q. Okay. I wanted to ask you, I think this is a document,

it's Exhibit 220, and it's a document of actually, Dr. Rogers. It'll just come up in a moment.

A. Sure.

Q. On that particular session, and I appreciate this is not your document it's hers, but she says the focus in that particular session with him was psycho-motor slowing. Just there we are.

A. Yeah.

Q. Is that something that ...

A. Can we zoom it?

Q. Just unfocus there and just zoom in on it.

A. So, typically the medication Risperdal, once the dose might be increased could cause that kind of problem of ... So, we tried to find him the medication to make sure it gives him best result and minimum side effects. But sometimes, especially when the dose is increased, the person might get some side effects that they might able to remember later on or able to convey later on.

Q. The medication that soldiers would take for PTSD, would that impact on their ability to return to duties that they might once have performed?

A. Some medication could do that, especially if they're on

high dose of sedating medication it could happen.

Q. As, I guess, through 2012, do you recall now if you saw improvement in Lionel Desmond's condition?

A. So as 2012 progressed he slowly started to respond to treatment. There were some days where things might not be going well and sometime it might be related to some negative news that might happen in his life. At one time he got news about health condition of his father that he got anxious and started to worry if he was going to get similar condition. At one time his wife send him a text that she wanted divorce and he started to worry and get anxious about it.

So he was making slow progress in terms of improvement but there were period where things might exacerbate depending on some of the stressors that was going on in his life.

Q. The ... I assume those what we might call external stressors, those are not uncommon for solders suffering from PTSD? Other things can intervene and make the condition worse?

A. Yes, other life events can occur and make things worse.

Q. Okay. Did you get a sense as he went on that he was hesitant to engage in treatment or was avoiding treatment at times?

A. I mean at that point I think he was cooperating with

the treatment. He was coming for almost all appointments. He was engaging with Dr. Rogers and I think towards the end of 2012 he completed therapy with Dr. Rogers. So he was able to successfully complete trauma therapy with her.

So until 2012/2013 he was engaging with us the way ... I must have seen him ... you know, during his involvement with us, you know, the rate of his not ... like missing appointments were very low. Most of the appointments he was attending.

EXHIBIT P-000190 - PSYCHIATRY PROGRESS REPORT - MAY 3, 2012

Q. Okay. So I'll just pull one document up. Let's look at Exhibit 190. So this one is ... if we zoom in at the top, it's a psychiatry progress report again, this one is from May 3rd, 2012, and on this occasion, I think Lionel Desmond was not doing well, I think you said further down. Maybe if we just scroll down to the middle of the page there.

One of the issues under the category of "Emotions Addressed" is "avoidance".

A. Mm-hmm.

Q. And I just wondered if having Lionel Desmond address or deal with his emotions was a problem or a struggle in his treatment?

A. So avoidance is a very difficult symptom to treat

(inaudible) treatment. So he was showing improvement in some symptoms but other symptoms such as social isolation, not able to do hobbies or pursue interest, those were there, as well as sometimes avoidance can manifest in therapy so ... But certainly in terms of his outside therapy functioning, avoidance started to manifest in his symptoms at that point.

And his stressors at that time were related to his father's diagnosis of multiple sclerosis and he was worried that he might get it himself. So it was a combination of external stressors as well as avoidance symptoms that were kind of creeping on him.

Q. You had said, Dr. Joshi, that his attendance at appointments was fairly good but he did miss some appointments I see from the documents. For example, Exhibit 191 is a Psychiatry Progress Report that you completed on June 6th and he didn't show up for his appointment on that day.

EXHIBIT P-000191 - PSYCHIATRY PROGRESS REPORT - JUNE 6, 2012

Did you get a sense that when he would miss appointments that it was as a result of emotional avoidance or wanting to avoid treatment?

A. So during my treatment or during the time that I saw him from 2011 to 2015, I had seen him ... I had appointments with him for approximately 32 to 33 times and the appointment missed

were about five or six. And the June 6th appointment was followed by his coming for appointment on June 19th.

So some of these appointments were missed because maybe it was conflicting with something else that was going on. So there were some appointments that he forgot and he kind of re-booked it within a week or two of the missing session.

So, for example, you know, he didn't come for July 20th appointment but he then came for July 18th appointment in 2013. So some of it could be avoidance, that he didn't want to come to us, or some of it might be just ... I mean, realistic reasons or understandable reason that he missed or forgot.

Q. Can you speak more generally? When you're treating patients with PTSD missing appointments and just organizational challenges, do those ... is that a problem for patients with PTSD? For example, getting to appointments or just organizing their life?

A. It can be problem for some members certainly and ... yes.

Q. And did you get a sense that that was something that he struggled with or are you able to say?

A. I mean in his case there was from 2011 September to the first appointment missed was there were a number of appointments

he attended on a regular basis. So I didn't get sense that he had some organizational difficulty in coming to appointments, some of them might be genuine reasons or just forgetting it.

EXHIBIT P-000193 - PSYCHIATRY PROGRESS REPORT - OCTOBER 2, 2012

(12:00)

Q. Throughout the course of this, as you look at the documents or as I look at them, it seems that the marital difficulties continued to be a consistent theme and perhaps a progressing theme. For example, if we could just bring up Exhibit 193, which is your psychiatry progress report from October 2nd, 2012. And just zooming in on your notes at the lower part of the document, you said: "Not doing very well. Recently, his wife has gone to NS and sent him a text to ask for divorce." And, later, you say: "Hoping wife will reconsider her decision."

Do you recall if the marital difficulties increased over the time that you saw him or were consistent throughout or can you comment on that?

A. I think it kind of fluctuated between wanting to be together to sometime wanting a separation. It was also impacted by a long-distance relationship with his wife's studies in Nova Scotia. So there were episodes where ... or they repeated where

sometime they were together or wanting to be together then some other time, he would get a text or message that she would want divorce. So this undercurrent of marital difficulty was there throughout and even from the first time I met him, it was there, until the last time I saw him.

Q. It was there throughout.

A. Yes.

EXHIBIT P-000184 - LETTER DATED OCTOBER 28, 2012

Q. Okay. So I want to draw your attention now to a document. This one is Exhibit 184. And maybe we can just zoom in at the top of the first page. This is a letter you wrote, I think on October 28th, 2012, to the Senior District Medical Health Officer, Veterans Affair Canada. So this would be about a year into treatment. And if we could skip over to the fourth page, just the very final paragraph, you said:

> When reviewed in late spring and early fall 2012, he continues to have significant problems with PTSD symptoms. They have gotten worse by wife deciding to separate from him. Cpl. Desmond continues to attend psychotherapy. His long-term prognosis is guarded, in light of poor response to

treatment, until October 2012.

So at that point there was ... obviously, you were concerned about his long-term prognosis or at least you described it as "guarded". Can you give us a sense of where we were in terms of the treatment at that point in terms of his response to it?

A. So this would have been my letter to support his Veterans Affair Canada claim for a psychiatric condition. And in that, it will be summary of my ... or mental health involvement for the year. So we kind of had one-year period he seemed to be struggling with PTSD symptoms with the undercurrents of marital difficulties and his wife wanting to separate at that point. Those kind of symptoms or those kind of events and his overall response made me kinds of be in a position to say that long-term prognosis is poor or is the treatment or his response until then wasn't satisfactory.

Q. I get the sense, and you can comment on this, that his relationship with his wife and his marital difficulties perhaps interfered with or hindered his long-term course of recovery from PTSD?

A. It would have been one of the factors that would have made negative impact on his recovery.

EXHIBIT P-000194 - PSYCHIATRY PROGRESS REPORT - NOVEMBER 6, 2012

Q. If we look at the next of your psychiatry progress reports, this one is Exhibit 194. And on this one, if we zoom in on your notes mid page there, you said: "Not doing very well. His wife visits him regularly but they fight a lot." So, again, we see the relationship factors impacting on his mental health. Do you recall if you had an opportunity to discuss with him or whether there was any options for couples counseling or anything of that nature for he and his wife?

A. Well, I think ... so I think at one point in time when he and his wife were planning to go for couples counseling, I think one of the problems was that she was living in Nova Scotia. So it was difficult to engage in long-term, like, couples counseling because she had difficulty to be locally available. But at one point, I don't remember exact date, she was at least able to come every alternate week for couples counseling and they were thinking about going for couples counseling, but I don't recall whether they went or not.

Q. You said that is something that was available to members and their families, if needed?

A. Yes. Couples counseling facilities are available for member and spouse if they indicate the need or willingness to

engage.

Q. And as this goes on, I get the sense that his symptoms or the severity of his symptoms tended to wax and wane. We were just looking at November 6th, I believe, where you said he was not doing very well. If we bring up Exhibit 195, which is your next report, I think from December 13th, 2012, you say in the mid part of it: "Feeling a lot better", I think is what you've written there.

EXHIBIT P-000199 - PSYCHIATRY PROGRESS REPORT - DECEMBER 13, 2012

A. So in November notes, he was having visits from his wife and he was going out more with his daughter and then he went on. So he was trying to overcome the avoidance and social isolation. At that point, his mother had come to stay with him to help with the daughter. And he was working in a new workplace. So he was able to go out more and he was able to ... he was in a different work environment and I think the therapy was starting to be beneficial. So cumulative effects of all this positive changes in his life was helping him to start to feel better.

Q. Was it your recollection and impression that he began to improve through 2013?

A. So he continued to improve in early parts of 2013. So

I think towards the end of February 2013, he was telling us that he was functioning well. He was taking more responsibility at work. He had completed therapy with Dr. Rogers and ... so, at that time, the plan was to ... if he continues to remain well, we were thinking about maybe slight reduction in his dose of medication to see if it will help him. And, at that time, we were considering to recommend a return to full duty as well as, you know, less restriction on his employment limitations.

Q. And those discussions were ... When did you have those discussions? Was that in early 2013?

A. So end of February 2013.

EXHIBIT P-000222 - PSYCHOLOGY PROGRESS REPORT OF DR. W. ROGERS - FEBRUARY 19, 2012

Q. Okay. So I'm just looking at a document. This one is Exhibit 222 and this is actually a document of Dr. Rogers, but in the first typed paragraph in the middle of the page she says:

> Cpl. Desmond completed prolonged exposure therapy for PTSD in the fall of 2012. Since then no recurrence of symptoms. He's been able to do a weapons course in the field without being bothered by the combat environment. He enjoys his work in Stores.

He's able to go in crowds without discomfort and to do other every day tasks. He says he doesn't think about Afghanistan much anymore. His mood seems stable.

(12:10)

And, again, she references the appointment with you on February 27th. And I think there's a psychiatry progress report from that same date that says much the same. Did you get a sense that he was being completely forthcoming about his condition at that time, that things were indeed better?

A. So at least from the behavioural aspect of it, it seems that he was trying to come out of social isolation. Avoidance symptoms seems to be less because he was getting out. He was ... he was going to field. He was taking more responsibility. As far as thoughts and intrapsychic emotions with his feelings, certainly he told me and Dr. Rogers that he was feeling better. And I think by that time I had seen him for almost one-and-a-half year. And so I think I got sense that he was truthful in reporting improvement because I think by that time we had established a good rapport with each other. But, again, that's my understanding.

Q. And so did you, in fact, ease back, I guess, on the

treatment through 2013?

A. So I would have reduced the frequency of followup to maybe every six week to every two months to see how he's functioning without more intense involvement with Mental Health. But I did see him in April of 2013 and, again, he was maintaining, you know, wellness. He was back to work. He was doing well except occasional upsets. So he maintained that improvement in April of 2013.

Q. There was an event, however, in September of 2013 that caused him to regress, I guess, or relapse. Perhaps I'll refer you to Exhibit 185.

EXHIBIT P-000185 - PSYCHIATRIC ASSESSMENT - SEPTEMBER 25, 2013

A. So September 2013 ...

Q. September ... the document that we're pulling up is a psychiatric assessment from September 25th, 2013, and there appears to be a referring physician. It would seem that CPO2 Cook referred Lionel Desmond back to you for psychiatric assessment.

A. So there was certain ... yes. So there was certain events that happened at his workplace that his primary care physician, Physician Assistant Cook, he asked me to see Cpl. Desmond again. So I think, at that time, there were things

happen at his workplace that caused significant setback to his overall health and so I saw him in that context.

Q. Okay. And about midway down the letter, you say: "He certainly has significant PTSD symptoms; however, his current issues seem to be related to workplace issues." And I'm just wondering if you recall whether ... if there was, in fact, a recurrence of his PTSD symptoms and if they were related to ... as you say, primarily to workplace issues at the time.

A. So he kind of experienced certain comments that were made in a racial tone and he reacted to that. But he had certain PTSD symptoms, like avoidance, anxiety in military environment triggers. So he started to get triggered. So one of the concern of the primary care physician was, Is it relapse of PTSD or is it reaction to his environment or workplace issues? So I felt that it was predominantly his response to the workplace issues. And so I called his primary care physician and asked him to maybe give him some sick leave as well as try to get him removed from the workplace, as well as try to address the workplace issues. I think one of the captain, who's a social worker, got involved as well to help him with his workplace issues.

Q. So were you able to satisfy yourself whether his PTSD at that time was a function of his workplace issues or ...

A. So it kind of ... certain symptoms got worse with the workplace issues, mainly triggers in the military environment and anxiety going to work. And that, in turn, caused more social isolation. But in my judgement, at that time, it seemed more like a reaction to the workplace issues.

Q. Would it have been unexpected for a soldier who had suffered from PTSD, such as Lionel Desmond, to be affected in that way by an event such as the one he experienced?

A. No. I think his response would have been understandable, considering what happened.

Q. Right. I guess what I'm wondering about is any kind of event when a soldier is recovering from PTSD ... any kind of negative event in their life, can it cause a relapse of symptoms or a regression in their condition?

A. Yes. And especially workplace. It can make things worse going to work.

Q. Was the treatment at that point in the fall of 2013, was it the same in terms of medication?

A. So his medication at that time were the same. I had given him some ... another medication just to help him with anxiety at that time, just when he was going to work or dealing with workplace situation. And then I made, again, arrangement to

see him in one week's time.

Q. But the medication that you had originally been treating him with, had that continued or had that been reduced?

A. No. That was continued. I think I remember asking him to take extra Risperdal, if needed. So if he was having a bad day, he could take an extra one milligram of Risperdal if he was not doing well. And he was also given a medication to help with anxiety to be taken as needed basis.

Q. So some of the meds would have been on an as-needed basis going forward? Was that the plan?

A. Yes, at that time, it was to deal with the immediate situation that he was experiencing, to kind of go work on that intense anxiety and agitation while we were trying to resolve his issues related to workplace.

Q. Okay. Was it your sense that he would be able to return to the duties that he had performed before in 2013?

A. I think, at that point, I remember asking his primary care physician to consider changing his workplace because I felt that going to the same workplace would cause more problems so that was my recommendation at that point.

EXHIBIT P-000187 - COMPLEXITY ASSESSMENT INTERVIEW QUESTIONNAIRE - NOVEMBER 18, 2013

Q. So let me just ... maybe we'll pull up a document. This one is Exhibit 187. Just ... we can zoom in at the top. This is something called a "Complexity Assessment Interview Questionnaire" and it's from November 18th, 2013. And if we just go down ... about halfway down the page, maybe, there's a paragraph that says:

> OSI (PTSD) and MDD diagnoses in 2011 associated with Afghanistan tour in 2007. Therapy completed in February 2013 with a recommendation that the TCAT could be ended.

That's the Temporary Category.

A. Yes.

(12:20)

Q. Dr. Joshi, psychiatrist, planned in February 2013 a recommendation to return to full duties and gradual reduction of meds. Between the summer and fall of 2013, the member's marriage ended and he also experienced work-related stress, racial comments, from some superiors which resulted in eventual ADR. Member experienced distress, thoughts of wanting to harm

someone.

That was when he had the incident at his workplace. So this document indicates that in February of 2013, you anticipated he might be able to return to full duties. But he had these setbacks or struggles with his workplace and his marriage. Where did you see him in the fall of 2013? Did you see him returning to his full duties or not?

A. So following the incident at workplace with the racial comments, he became extremely symptomatic. So I think, at that time, it was difficult to consider him to go back in the same work environment. So it started to appear that he was not really recovering and stressors were triggering ... or stressors were causing relapse of his symptoms. Although they may not be as intense as initial presentation, but still it was making things worse. So that time kind of sense started to come that maybe he was kind of not clear recovering and stressors of life were causing setbacks on a regular basis.

Q. And you continued to see him throughout 2014. Is that correct?

A. Yes.

Q. There are a number of psychiatry progress reports through 2014. Do you have a recollection of how his condition

changed or how he presented throughout 2014?

A. So once he was removed from his previous workplace and placed into new workplace, and he went through ADR process and he started enjoying his new workplace and there were no racial issues at the new workplace, he started to settle down. And I believe he started to re-engage with Dr. Rogers at that time. I don't remember exact dates but around that time, Dr. Rogers started to get involved again. So I think cumulative effect of different workplace with better work environment, ongoing followup with myself and Dr. Rogers, he started to report that things were getting better for him.

Q. He was still actively, I guess, under treatment then through 2014, regularly seeing you and seeing Dr. Rogers?

A. Yes.

Q. Okay. And again it's difficult, but did you have a sense of what his prognosis was through 2014?

A. So based on previous incidents where he had significant setbacks after a significant life stressor, it appears that he probably was not able to face, you know, recurrence of different life stressors on an ongoing basis. So although he was functioning better, there was no guarantee or no conviction that if next setback occurs, if he would not decompensate. So at that

time, long-term prognosis appeared to be kind of relapses of symptoms, like periodic worsening of symptoms.

Q. So the concern going forward was that ... what was the word you used "decompensate"? Was that the word you used?

A. Correct. Yes.

Q. What does that mean?

A. It means ... it would mean deterioration in his symptom as well as his functioning in his life.

Q. Okay. So any external stressor, at that point, caused you concern that he would decompensate that his symptoms would become worse?

A. So the history until that point suggested that any time there was a difficult situation, workplace or relationship, his symptoms are getting worse. So it appeared that any major psychosocial stressors was making his symptoms worse.

Q. Okay. Did it appear to you that that might be a long-term situation for Lionel Desmond?

A. It appeared to be that way at that point.

Q. Okay. What did you see his future in the Canadian Armed Forces as 2014 progressed?

A. So at that point it started to become kind of clear that he couldn't do full-time ... full duty role as a soldier.

And probably triggers in the military environment and risk of re-trauma if he was to be deployed again would make things worse. So, at that point, it started to appear that maybe he would start to look to get release, kind of medically or try to get out of military on medical ground. So it started to appear that he might not able to function in full capacity in the military.

Q. And some of the duties that he would have had as an infantryman would have been obviously very difficult for him with that condition ongoing?

A. That's correct, yes.

Q. Okay. And, at some point, you described the process of being in the temporary category, or TCAT, and then ultimately a member who is going to be leaving, moving over to the permanent category, or the PCAT. Do I understand that correctly?

A. Yes. Yes, so that would be the process.

Q. And, at some point, Lionel Desmond moved from the TCAT category to the permanent category?

A. That's correct, yes.

EXHIBIT P-000186 - MEDICAL EXAMINATION FOR ADMINISTRATIVE PURPOSES - OCTOBER 22, 2014

Q. Okay. So I want to draw your attention to ... again, this is not your document, but I just want to ask you about it.

This is Exhibit 186. And maybe we can just zoom in at the top. This document is signed by Capt. Patrick Gilbride, MD. So that's a doctor in the Canadian Armed Forces, is it?

A. Yes. He would have been a medical officer, like family doctor equivalent.

Q. He would have been a family doctor then treating Lionel Desmond at the time or responsible for him?

A. Yes. So he'll be primary care physician. Yes.

Q. Okay.

A. Or who might have seen him at that point.

Q. Right. Okay. So this document is dated October 22nd, 2014. It's called, "Medical Examination for Administrative Purposes." You said:

> Member requesting to have paperwork complete for Office of Provincial Firearms Officer, stating he is fit to have a personal hunting weapon. First encounter for member with writer, typically followed by Nurse Practitioner Weber. Member had PCAT completed for PTSD.

So, at this point, Lionel Desmond has had his PCAT done or he's in the PCAT ... the permanent category. Is that correct?

A. Yes.

Q. Okay. And that was for his PTSD condition.

A. Yes.

Q. And it says, "With ARMEL decisions ..." Can you help us with that acronym, if you're able?

A. "MEL" is kind of medical employment limitation. "AR", I'm not sure what it means.

Q. Perhaps "administrative review" or ...

A. Possible. Most likely.

Q. Okay. But the "MEL" is medical employment limitations? We just froze again, did we? Able to hear me, Dr. Joshi?

THE COURT: Mr. Murray, what we're going to do I see we're coming on 12:30, so we're just about to take a break anyway. I think this is a good spot to break just in terms of your questioning at any rate ...

MR. MURRAY: Sure.

THE COURT: ... if you don't mind. Dr. Joshi, can you hear us?

DR. JOSHI: (No response.)

THE COURT: All right. In the meantime, Counsel, we're going to adjourn for lunch. Be back at 1:30 and we're going to continue to try and reestablish a link with Dr. Joshi. And just

advise him we've adjourned for lunch, be back at 1:30. All right. Dr. Joshi?

DR. JOSHI: Yes.

THE COURT: Can you hear me?

DR. JOSHI: Yes.

THE COURT: I know you can't see me, but you can hear me. Oh, there I am. You froze for a minute during the question that had been posed by Mr. Murray. So I think what we're going to do is ... it's 12:30 here, so we're going to break for lunch for an hour ...

DR. JOSHI: Okay.

THE COURT: ... if that's fine. And Mr. Murray will continue with the last question that he asked just before we lost the connection with you. But we'll reestablish connection just shortly before 1:30, then come back for the afternoon.

DR. JOSHI: Okay. Thank you.

THE COURT: All right. Thank you for your time. Thank you.

DR. JOSHI: Thank you.

COURT RECESSED (12:30 HRS)

COURT RESUMED (13:32 HRS)

THE COURT: Good afternoon, Dr. Joshi.

A. Good afternoon.

Q. I think we're ready to proceed, Mr. Murray. I think we had lost the audio just about a time when you were asking a question in relation to Exhibit 186, so maybe you could pick up from there.

MR. MURRAY: Yes, Your Honour, thank you. It was Exhibit 186 we were referring to, if you could bring that up again. Thank you.

Doctor, when we broke, I was asking you about some of the acronyms in this and we determined that "ARMEL", the "MEL" part, at least, is "medical employment limitations". Is that correct?

A. Yes.

Q. Do you know specifically what Lionel Desmond's medical employment limitations were?

A. So generally speaking, the medical employment limitations would include things like not handling military weapon, not handling explosive, not driving DND vehicle, or not going into field exercise. So these are some of the standard medical employment limitations that a member is placed on.

Q. And would those be typical of members who are suffering from post-traumatic stress disorder?

A. Those would be typical for any member who is seeking

mental health treatment. So that might be the case for depression, anxiety disorder, any other psychiatric condition as well.

Q. Okay. So basically any psychiatric condition, those would be typical MELs.

A. So those MELs will kind of protect member from going into field or going into career courses or getting tasked out to another base so that it gives them time to focus on improving their mental health or work with their treatment team. So these kind of restriction kind of allows member to take more participation in their mental health treatment.

Q. Would those ...

THE COURT: How do ...

MR. MURRAY: Go ahead.

THE COURT: Doctor, I was going to ask, how do they get imposed? Who makes the decision that there should be limitations?

A. So these decisions are usually made by the primary care physician, or GDMO is what we call it. So it's the ... MEL is the responsibility of the primary care physician.

THE COURT: Thank you.

MR. MURRAY: Do you have a sense in this case, Doctor, of

when those would've been imposed on Lionel Desmond?

A. So it would have been generally imposed when he first start accessing mental health treatment. I don't recall exact dates, but generally, it's the time when someone starts attending mental health services.

Q. So in his case, he started accessing mental health services in 2011, so presumably then?

A. There was a period where he had improved and gone to full duty, so I'm not sure if, at that point, when he went back to full duty, whether his MEL or his restrictions were relaxed, but maybe they were reimposed after when he had worsening of symptoms. So I'm not ... I don't recall exactly when it might have been imposed or taken ... relaxed.

Q. Okay. When this ... The entry that we're looking at now relates to his application to have a firearm personally. If a member has an MEL that prohibits him from possessing a weapon as part of his work, is there any, I guess, relationship to whether he can possess a weapon personally or not?

A. So a restriction of military firearm is a part of his medical employment limitation, so it is put on members with various psychiatric conditions. Some of them are minor, some of them are serious, but essentially, it kind of allows member to be

taken away from their work responsibility and get into treatment mode. So it does not necessarily mean that assessing primary care physician has determined that this member is a risk to themself or might be potentially violent. It's a kind of generic restriction that is put on member to allow them to take care of themselves.

Their personal weapon is more individualized so many ... I mean very high percentage of members that we see will have personal weapon and sometimes those two may not be one versus other. So, for example, a lot of member enjoy the, you know, when hunting season starts or they enjoy going to the range with their friends. So is it a hobby for them, going with their friends to various activities, while someone with PTSD who is going into field and trying to use a military weapon, it might be triggering them. So there are certain nuances to this issue.

Q. Okay. In this case, the entry from Cpt. Gilbride says that the ARMEL decisions in May 2014 stating that Lionel Desmond was not fit to safely handle a personal weapon, would they typically ... would that be correct, do you think? Would they typically refer to a member possessing a weapon personally as well as part of employment?

A. So I think he must have had his personal weapon, but I

know that some point in his treatment, so Cpl. Desmond, must have presented to get his personal weapon back and that's where he must have made the entry.

Q. Okay. And the paperwork from the New Brunswick provincial firearms office, that was provided to you at some point, was it?

(13:40)

A. I think I remember filling, but I don't ... I mean if you could put it forward, then I can see it, the document.

EXHIBIT P000136 - REQUEST FOR TERTIARY INVESTIGATION - SEPTEMBER 22, 2014

Q. So I think we have this marked as Exhibit 136. So this is a multi-page document.

A. Mm-hmm.

Q. And perhaps the best way to do this; first, you can just scan down the first page and just look at the typed portion. If you recall if this portion of the document was provided to you or not. This would be in late 2014.

A. So it kind of reports that in November 2014, or in December 2014, I had a call with the firearm department.

Q. Yes.

A. And so I assume it's accurate. I think it's accurate.

Q. Do you have a memory of speaking to a firearms officer; specifically, Joe Roper?

A. I don't remember the name but I remember speaking to a firearm officer.

Q. Okay. And on that document, if we could just flip over to page 6 and maybe zoom in there, further down where the signature is. Is that your signature, Dr. Joshi?

A. Yes, yes.

Q. Okay. So this was completed in September ... sorry. You might have to help me with the date there.

A. I think it's the 4th of ...

Q. 4th of November?

A. 4th of November 2014, it looks like.

Q. Okay. So do you have a memory now of completing that document?

A. Yes.

Q. Okay. And if we could just go back to the first page, it looks like, according to Firearms Officer Roper, he had the conversation with you on December 2nd, 2014?

A. Yes, it must be true, yes.

Q. Okay. All right. So I know you have some difficulty remembering the specifics, but do I understand that you do recall

speaking to the firearms officer?

A. Yes, I do.

Q. Okay. And can you just tell us. At that time, you checked the box that you felt Lionel Desmond was ... I guess the wording is that he did not pose a safety risk to himself or others in possessing firearms. What was your thought then when you were asked to complete that form?

A. So by that time in October and ... so by that time, Cpl. Desmond was functioning better. He had ... he was stable. He was not having any major problems. He was feeling good. He was enjoying his workplace. There was no concern about suicide or violence. He was thinking about future and he was happy about getting two-year retention at that point and he had a good summer. So with that, he seems like he was stable for a period of time.

Also, he was looking forward to going with his friends for hunting and on the range, so it was ... he was trying to come out of his social isolation and trying to reach out with his friend. And I think a lot of members, especially in the military, they have ... you know, they value their hunting season and value their time in the woods with their friends. So he was looking forward to that.

By that time, he had demonstrated that he had ... you know, he was in control of his emotions and anger, and when he was dealing with the racial comments and was feeling angry, he had voluntarily handed over his weapon to his friend for safekeeping. So it showed to me that he was, you know, dealing with his issue responsibly. So based on that, I had conversation with the firearm personnel and I indicated that I felt that he was okay to have his firearm back.

Q. So a couple of questions. One, when you spoke to the firearms officer and completed the form, what was your understanding about how that information would be used? In other words, did you feel ultimately that you were making the decision or was it your understanding that the firearms officer would be using other information and ultimately concluding whether to grant a license again or not?

A. My understanding at that time was that I was one of the informant to the firearm officer and he might rely on my judgment more than others, but I might be one of the people that he would contact to make his decision.

Q. At that time, Lionel Desmond was still under your care and was being treated by you and medicated.

A. Yes.

Q. At that point, his departure from the Canadian Armed Forces was upcoming, I think. Is that correct?

A. Yes.

Q. Was there a concern that when he left the Canadian Armed Forces that there could be any break in his care or that he could regress and maybe shouldn't have firearms?

A. So throughout, from that time until his release, he seemed to be functioning as ... he was kind of stable. His worries were kind of normal worries of anybody who is getting released. So worries about finances, worries about where to live, what next career. So they were kind of normal worries about, you know, phase of life where transition was occurring.

So at that point, I did not feel it was sufficient to kind of ask for his firearm to be taken back.

Q. All right. So that was in December of 2014. You continued to see Lionel Desmond through at least the first half of 2015. Is that correct?

A. Yes.

Q. From a couple of entries in 2015, it appeared that he continued to have concerns about his relationship. Is that your recollection?

A. Yes. He was ... when the release was upcoming, he

wanted to, I think, sell his house or make plans for the future, and I think he was not sure about his wife's response, so he was unsure if she wanted to be together or what was happening.

So that underlying relationship concern was always there and it was impacting him at that point with not being sure about what he was going to do.

EXHIBIT P-000216 - PSYCHIATRY PROGRESS REPORT - FEBRUARY 18, 2015

Q. So I'll ask maybe if we could pull up another exhibit. This one is 216. So this is the psychiatry progress note from February 18th, 2015. And just zoom in on your notes again there. You said: "Member is doing okay. Getting released from CF in the next four to six months. He continues to be concerned about his relationship with wife. He is not sure if she wants to be in relationship."

So, again, that was obviously, or was that a topic of conversation on February 18th, 2015?

A. Yes. This kind of back and forth in the relationship was always there. So at that time, as he was making plans about future, specifically what he wanted to do after he was out, he wanted to have some definite answers from his wife about their future plan as a couple. So I think he was unsure what was going on.

Q. When a member is leaving and continues to have a psychiatric diagnosis and there appears to be some strife in their marital situation, does that pose a concern for treating physicians, psychiatrists such as yourself?

A. I mean at that time, again, he was not showing any psychotic symptoms. He was not expressing any thoughts about suicide or violence. So at that time, it seems like he was managing well considering, you know, what was happening in his life. So this background of undercurrents of relationship issues was there from day one. It was not something new that could have made us, or made me concerned that maybe we need to rethink about his firearm.

(13:50)

Q. And just on another note in that entry that we were just looking at from February 18th, 2015, it says: "Patient is thinking about medical marijuana." Did you have occasion to speak to him about the use of medical marijuana?

A. Yes. So that was the time when a lot of members in Gagetown were trying medical marijuana. It was becoming widely available, so a lot of members were asking about it and going to community physicians to get a prescription of medical marijuana. So his friends were taking medical marijuana, so he wanted to

discuss with me. So we had discussion about medical marijuana and I was discouraging him to go in that direction.

Q. You say you were discouraging him from that?

A. Yes.

Q. What was your concern about the use of medical marijuana?

A. So in those days, the medical marijuana was prescribed to several members and there were concerns about, you know, potentially medical marijuana causing worsening of or causing psychotic symptoms or worsening paranoia.

Also, a lot of members were stopping their psychiatric treatment when they were going into medical marijuana. So there was concern about, you know, prescription, the amount of marijuana prescribed, as well as potential impact of marijuana on someone with psychiatric diagnosis.

So some of those reasons were driving me to discourage him to use medical marijuana.

Q. Has the science progressed since then? Is this a more viable treatment today or is it still something you would discourage amongst members in that situation?

A. So at that point, what we were seeing was that a lot of members were getting prescription of large amount of marijuana

dose during the day. Anywhere from six to eight grams a day and very limited follow-up. So some of them were approaching online pharmacy or online physicians and getting prescription with a one-year supply without any follow-up. So all those were concerning. So if someone is prescribed a medical treatment without follow-up, then it's cause to be concerned.

Over time, I think now with marijuana being available in cannabis stores and little bit more .. the hype has kind of subsided to some extent because, at that time, it was promoted for every psychiatric disorder. Any and every psychiatric disorder, we were seeing getting prescription of medical marijuana.

So I think now things are much more middle-of-the-road kind of approach. So people are getting lesser amount prescription. They are getting more follow-ups. They are getting more edible form of medical marijuana rather than with high CBD content.

So I think even the number of people who are going for medical marijuana have become more modest in their expectations. So although we still ... I mean I still don't recommend medical marijuana, but a lot of members do it anyway and ... but at least there is a trend towards more moderation in the last couple of years.

Q. You said that marijuana can cause symptoms of paranoia and, in some cases, psychosis. Can those be longer lasting even if an individual ceases to use that drug, or are you able to say or express an opinion on that at all?

A. So in my opinion and my experience with patients who have this issue is that marijuana can cause, like, substance-induced psychosis, especially when someone is taking high amounts and especially with high potency THC-containing products. They can have cannabis and marijuana-induced psychosis, but in some other people, they could precipitate a psychotic episode and that can perpetuate even after marijuana consumption is stopped. So we have seen both kind of scenarios in different patients over time.

Q. And it's still not something that you recommend for your patients in any circumstance?

A. No, I mean once the discussions start, I try to not recommend that, but if person is really wanting to try, then recommendation would be to try as low as possible, preferably edible and preferably smallest amount possible, but I don't prescribe medical marijuana, but a lot of patients I see will do it anyway.

Q. Right. Doctor, you said, or you said earlier, that

many of the members that leave the CAF in New Brunswick will start to go to the OSI clinic in New Brunswick.

A. Yes.

Q. Was that the expectation with Lionel Desmond when he was planning to leave the CAF?

A. Yes, yes.

Q. Is that something that you would recommend? Or I'm just wondering about the mechanism. Or is it something that would be almost automatic?

A. So as members start to get released, they will start having discussions about continuative care. And in that continuative care process, member will be made aware that there is an OSI clinic in Fredericton that is geared towards releasing member and then with their consent, they will be referred to that clinic for follow-up.

So typically, I would refer them about three to four months in advance of their release date so that there's enough time gap for their first appointment with their new clinicians in the OSI clinic.

Q. Okay. And in his particular case, the OSI clinic was a good option for him, was it?

A. Yes. I mean he had PTSD and they were a good option

for him to follow-up after he's out.

Q. The circumstances of a member leaving the Canadian Armed Forces and that transition to civilian life, can you say, from your observation, the effect that that has on some members? The stress that it causes?

A. So transition is kind of stressful to, I mean, almost all members who are getting released, especially if they ... because military career is kind of way of life. So it's kind of giving up something that someone is familiar with for a long period of time, and going into unknown is a stressful event, stressful change of life. And so we encourage members to access various services that might be available to them in terms of ... so various aspects might include things like mental health continuative care, physical health continuative care, their Veterans Affair entitlements, pensions, career plan if they're interested in training, retraining them, looking at what retraining they might want to pursue.

So it's a whole gamut of events that occur between their release date being known to actually getting released. And multiple people are involved into that process in doing their own kind of part. And, typically, a case manager would take a lead into that and try to make sure that a person is connected with,

you know, all their finances, pension, VAC, all those layers that a member has ... can access.

Q. And Lionel Desmond's release from the military coincided, I guess, with stress in his personal relationship or continued stress in his personal relationship. Is that correct?

A. Yes.

EXHIBIT P-000217 - PSYCHIATRY PROGRESS REPORT - APRIL 16, 2015

Q. I'll just refer you to another exhibit, one of the last psychiatry progress notes. This one is Exhibit 217. And just, again, if we could zoom in your notes halfway down there, you said: "Not doing very well. Stressed out about upcoming medical release. Planning to put house for sale. His wife is not very communicative about her intention to stay with him or separate. Financial concerns are increased (I guess,) but no SI or HI."

So that seemed to be the focus of your observations on that occasion on April 16, 2015, were the marital problems that he was having?

(14:00)

A. So, again, I think this was again same continuation of long-term marital problem that he wanted to sell his house, and I think he wanted to make plans about where he was going to go and where he was going to live and he needed to know his wife's

intention about what was the plan for them as a couple. Also, I mean he was getting out of military. So there was concern about his pension and income and what they can afford life as a retired military personnel.

So these were kind of stressors that were there, but again, he was not having any psychotic symptoms. He was not suicidal or violent. I think the mention of suicidal ideation and violence is really rare. You know, if he had indicated that he was feeling suicidal or violent, then intervention could be something different, like suggesting hospitalization, things of that nature.

So although he was dealing with the stressors of release and lack of communication from his wife he was still managing stressor with some worsening of his symptoms, and a lot of it was normal anxiety of heading into unknown after release.

Q. Did you discuss with Lionel Desmond, or did you note over the time that you dealt with him, if he had any substance abuse issues or if that was something that he used as a coping mechanism?

A. So substance use issues were ... would be discussed and I think, if I remember correctly, it was not an issue initially. But towards the end I think he was seen by addiction counsellor,

and again, I can't remember the assessment details. But again, substance use or abuse is a dynamic issue. So if ... I think he was seen by addiction counsellor maybe in early 2015 or around mid 2015.

Q. Well, we actually have ... I can refer you to ... it's Exhibit 225. And just zoom in at the top, maybe the first page. This was a document completed by Gail MacKenzie, addictions counsellor, on May 20th, 2015.

A. Mm-hmm.

EXHIBIT P-000225 - DEPENDENCY ASSESSMENT - MAY 20, 2015

Q. And she says at the beginning: "Member self-referred due to concerns with his substance abuse." I don't know if you recall if you noted whether his substance abuse was potentially on the increase when he was leaving the CAF. Or do you have a memory of that one way or the other?

A. So I think when I saw him last was in April or May. I don't think there was concern about substance use at that point but my recollection is not as good now.

Q. Okay, and just on the last page of that document. The conclusion was: "Member was assessed both objectively and subjectively and was found to have a high probability of having a substance abuse disorder. Member will continue to follow with

writer."

I would assume that someone who has ongoing struggles with post-traumatic stress disorder and other stressors in their life often use alcohol to cope with that. Is that ...

A. Yes, yes.

Q. All right. I think maybe your last psychiatry progress note, which is Exhibit 218, was from June 16th, 2015. And if we just zoom in on your notes further down. You said: "Member is getting released next Friday." So would that have been perhaps your last visit with him in June of 2015?

A. Yes, a week before his release.

EXHIBIT P-000218 - PSYCHIATRY PROGRESS NOTE - JUNE 16, 2015

Q. Okay, and how ... do you have a recollection of how you found him there before his release?

A. So as I indicated in my notes, he had normal anxiety about future job prospects, money. His house was in the market at that time. There were not too many people coming to see the house. His wife had started working in IWK Halifax, and again, he was not sure about their ... how it was going to proceed. He had a follow-up appointment with the OSI clinic. So at that time, usually members, when they're releasing, they get three months' supply of their medications. So he was given

prescription for three months so that it will tide him over until he gets connected with the OSI clinic.

Q. Okay. And in terms of ensuring that he gets connected with the OSI clinic, whose responsibility is that?

A. So typically, when the referral to OSI clinic is made, within a few weeks the member ... there's an intake assessment done by OSI clinic staff. So they kind of get member into their system, so to speak, and give a follow-up appointment. So I would typically ensure that they have a follow-up appointment, and so we are assured that there's a continuity of care.

And I think he had intake assessment done with the OSI clinic on the 7th of May. Somewhere around that time.

Q. And would you have seen him personally after that visit on June 16th, 2015?

A. No. So once member is released, then normally we won't see a member unless there is some bridging problem where, you know, in the immediate future after they're released if they have any concern, they can call. But generally, if they have appointment coming up in near future, then that would be the last time I would have seen him.

Q. And specifically with respect to Lionel Desmond, you didn't see him again after that, did you, then?

A. After that I didn't see him.

Q. Okay. Do you recall if, in his case, you were consulted by physicians from the OSI clinic or not?

A. I don't recall.

Q. Okay.

A. I don't remember.

Q. The last document that I'll refer you to is Exhibit 226. It's a discharge summary, and this is actually dated June 13th, 2016.

EXHIBIT P-000226 - DISCHARGE SUMMARY - JUNE 13, 2016

A. So it's completed by one of the mental health nurses, Ellen Morris. So this is really a more kind of administrative thing that is ... his file is still open in our database. So she's putting notes to close the electronic medical file. So the note reflects the person is being terminated at our clinic.

Q. Obviously ...

A. It doesn't mean that there was any clinical services given to the member.

Q. I see. All right. And obviously, he was discharged a year before that.

A. Yeah, so if she goes through the patient list and over time the ... you know, close the cases that have been discharged

or the treatment is completed. So it's more an administrative completion of ... completing the loop so to speak.

Q. That document in the plan or recommendation says: "Member released and to be followed in the community if needed." When Lionel Desmond left the Canadian Armed Forces did you have a sense then of what he would have needed going forward in terms of medical treatment?

A. No. I think that probably doesn't reflect ... it's an administrative document. So when he was released in community it was understanding from me that he will be followed in OSI clinic Fredericton.

Q. Right. And just more generally, what did you think he would need going forward in terms of his medical treatment?

A. So he would need a similar replication of the services that he was having with us, that is, psychiatrist still manages his medication, follow-up, and therapy on an ongoing basis and ability to access emergency services if required.

(14:10)

Q. And did you have a sense of how long that might need to go on?

A. I mean his long-term prognosis was guarded. So there are many members who, once they get out of military, once they no

longer face the military environment, their symptoms improve because they're not triggered on a day-to-day basis of military environment. So they might require less intense follow-up but there are some other members who would require as intensive followup as they were getting before.

So I think in his case, his situation, it was obvious that, you know, many time when psychosocial stressors occurred he was showing regression. So it kind of indicated that even in civilian life he would need ongoing follow-up with the OSI clinic.

Q. All right. Thank you, Doctor. Just one moment.

Just a question. You had said, Dr. Joshi, that, you know, external stressors had the potential to cause a patient like Lionel Desmond to decompensate or to regress or to exhibit a worsening of symptoms. And I'm just wondering. When you spoke to the firearms officer, Mr. Roper, appreciating at that time that you were treating Lionel Desmond, at that moment he may have been doing well. Did you convey to Mr. Roper that there was the risk of a decompensation or that he could regress with certain external stressors?

A. No, I don't recall that, no.

Q. Okay. Is it important, do you think, for individuals

who are making those decisions about firearms to have a more complete picture of the risk that's associated with a patient given potential stressors in their life going forward? Do you think more information might be helpful in those circumstances?

A. So he had firearms even when he was significantly ... even when he started ... even before he started the treatment and he had, I think, firearms for a long period of time with treatment and without treatment. So I think this undercurrent of marital problems were occurring and he was seeking appropriate help, you know, when he required. He was handing over a weapon to a friend. Or he was telling us that he was not feeling well when, you know, things happened in his life at work.

So I think at that point I did not tell ... I don't remember telling that this might be issue that they need to pursue after he's out of the military.

Q. Sure, but even setting aside Lionel Desmond, just more generally, is it better, or do you see some value in firearms officers when they're making these determinations seeking more information from doctors such as yourself so that they have a more complete picture of the risks?

A. Yes, there will be value. Yes.

Q. All right. Thank you, Dr. Joshi. Those are the

questions I have, but other counsel will have questions for you.

A. Thank you.

THE COURT: So Ms. Ward, I'm going to let you go last or you can go now if you like.

MS. WARD: I'd like to defer.

THE COURT: All right. Thank you. So you can defer. Mr. Anderson, do you have any ...

MR. ANDERSON: I have no questions, Your Honour.

THE COURT: No questions? Okay. Mr. Macdonald, do you have any questions?

MR. MACDONALD: Thank you, Your Honour.

THE COURT: So Mr. Macdonald, what I might suggest is that because of where you are you might be just as well off using the podium, please.

MR. MACDONALD: Okay. I'll do that. Sure. Thanks, Your Honour.

THE COURT: If it's convenient for you.

MR. MACDONALD: Thank you.

CROSS-EXAMINATION BY MR. MACDONALD

(14:14)

THE COURT: Dr. Joshi, this is Mr. Macdonald. He has a

couple of questions for you. Thank you.

MR. MACDONALD: Good afternoon, Dr. Joshi.

A. Okay. Thank you. Good afternoon.

Q. My name is Tom Macdonald and I'm the lawyer for the Borden family. So that is the family of Mr. Desmond's late wife and daughter.

A. Thank you. Yes.

Q. Thanks. Sure.

Doctor, I just wanted to ask a couple of questions because I'm a bit unclear. So in around four-plus years that you were seeing Mr. Desmond did he have suicidal thoughts? I know he didn't act on things when he was with you but did he have suicidal thoughts?

A. So initially when I first saw him he had suicidal thoughts but no kind of well-developed ideas or plans. So these were ideas that he had but they subsided within a short period of starting treatment.

Q. Okay. Is it fair to say that in all of the sessions that you were with Cpl. Desmond that at times he exhibited anger?

A. Yes, he had anger problems. Yes.

Q. Would you say it's fair to say that he exhibited anger in almost every session that he spent with you?

A. I think anger kind of fluctuated, you know, between sessions. Or sometime it was under control. Sometime it was not. But anger was one of the symptoms that he had.

Q. I wanted to go through and I don't mean this list to be exhausted ... or exhaustive, I should say. So from listening to your evidence so far today, and you tell me if you think I have something wrong or if I'm portraying it unfairly. I'm not meaning to do that deliberately. So Mr. Desmond was a combat veteran. He actually fought in firefights, correct?

A. Yes.

Q. And he had PTSD. You diagnosed him with that.

A. Yes.

Q. He did have, which you've just said, some suicidal thoughts at a point in time during the treatment sessions.

A. Yes.

Q. And there was an undercurrent - I think that was maybe a word you used "undercurrent", I'll use it too, with marital issues. Is that fair?

A. Yes, true.

Q. He was restricted from using military weapons.

A. Yes.

Q. He had his New Brunswick firearms license placed under

review and you were a person that he had asked to try to help get it back for lack of a better way to put it is ...

A. Yes.

Q. Yes. He also had ... there was an incident where and I think he told you that he had to take his personal weapons to a friend's house to lock them up because of the racial incident in 2013?

A. That's correct, yes.

Q. Just to focus on that incident for a moment. Isn't that in and of itself a very significant red flag even though it's the civilian side of life that if I feel that I'm so disturbed by someone that I have personal weapons and I need to take them to my friend's house because ... well, let's speculate. Because I might use them with the person that I have a problem with? Isn't that a big red flag?

A. So I think it is an issue that needs to be concerned with, but I think his response, I thought, was much more appropriate; that when he was dealing with that racial incident he asked voluntarily his friend to take over the weapons. So ... and when the incident subsided and when he started to feel better he must have got it back.

So I took it more as a sign of being in control rather than

losing control.

Q. Okay. Would you agree that perhaps other psychiatrists may have looked at it from the opposite side, which is it's a sign of not being in control if you have to put your weapons in the nextdoor neighbour's house?

A. It's possible, yes.

Q. Okay. I'm just going back to my list of factors. He was also using medical marijuana, which I know you're not a proponent of, at the time that he was seeing you or toward the end part.

A. So he was thinking about it but he wasn't using it ...

Q. Understood, sure. And, of course, he was being discharged in the next four to six months after that last meeting that you saw him.

(14:20)

A. Yes.

Q. Would you agree that all of those factors, once your file ... and you made a recommendation to refer him to NBOSI? Correct?

A. Mm-hmm.

Q. Yes?

A. Yes.

Q. Sorry. Yes. So ... and I believe, we don't need to turn to it unless you feel you need to. But on your referral form you have an annotation and part of it says: "See file notes." I may not be stating it correctly but see your file notes is what it referred to.

A. Correct.

Q. Yes.

A. Yes.

Q. So would you agree that the next stage in his treatment, let's say NBOSI, anyone getting your file, if they had looked at your file notes they're going to be able to pull these various factors that I just listed from you from your file notes if they read them? Is that fair?

A. Yes. They will have access to my notes and they will also make their own independent assessment based on their kind of understanding of his situation.

Q. Do you know, or are you aware, of any changes you have made in your own medical ... your psychiatric practice or in Canadian Armed Forces as it relates to you being an independent contractor since this incident? Are there any changes that you can think of that have been implemented in the way you see, say, combat veterans and assess them?

A. I'm not sure. Any particular area you're looking information for?

Q. So you saw this patient, and of course we know ... not while he was with you but ...

A. Mm-hmm.

Q. ... we know what happened, which is the incident that brings us here today.

A. True.

Q. So as a result of that very significant incident with this ex-Forces member are you aware of any changes that either you've made to your practice personally as a contractor with the Armed Forces, or directives that have come down on high to you, to make any kind of changes?

A. I think ... I mean obviously one is more sensitive to these kind of incidents and probably plays on your mind, you know, when you're dealing with any patient. But I'm not sure if there are any major changes that I've noticed. I mean we still would assess for suicide risk or violence risk same as before. Or maybe assess firearm safety same or similar manner as before.

But in the actual personal level you certainly are more sensitive to something like this could happen. So I think at a personal level you might be more responsive to this, you know,

tragic event.

Q. Sure. Do you think it would be helpful going forward to be able to perhaps put a specific section on the referral form where you might be able to list certain factors? Not necessarily all the ones I listed for you. But certain factors so that immediately upon referral the first person who picks up that pile may see a little overview or an outline jumping out at ... Would that be of any assistance to you?

A. So I think there are advantages and disadvantages with that approach. So if you kind of narrow it down to a few points. Because a referral cannot be too, too lengthy. So if you narrow it down to very specific few points, then you might miss the details. And sometime the details might not be related to violence or suicide. It might be a side effect of medication. It might be unique characteristic of that particular person.

So it might be better for person who is taking over to read the whole document where there will be much more detail. So there are advantages and disadvantages of both approach. So I think ... you know, I would believe that they will read whole document and, you know, make their own judgment after their assessment of the person and not just rely on a referring

agency's referral documents.

Q. Sure. Thank you. And Dr. Joshi, so is it fair to say that you would expect, when you send the file on, that the next reviewing person or agency is going to read your notes, read your file? The file notes?

A. Yes, and that would be assumption, yes.

Q. Yeah. Thank you very much. I appreciate your patience.

A. Thank you.

Q. Thank you.

THE COURT: Thank you. Ms. Miller?

CROSS-EXAMINATION BY MS. MILLER

(14:25)

MS. MILLER: Good afternoon, Dr. Joshi. Can you hear me?

A. Good afternoon. Yes, I do.

Q. My name is Tara Miller and I'm the lawyer representing the late Brenda Desmond. So Lionel Desmond's mother.

A. Mm-hmm.

Q. And I also share representation with Mr. Macdonald, who just asked some questions, with respect to Mr. Desmond's daughter, Aaliyah.

A. Sure.

Q. A few questions for you. I believe I understood your evidence to be that you've been working with the Canadian Armed Forces in Gagetown providing psychiatric services since 2007 when you were recruited to join the Canadian Forces as a civilian contractor?

A. That's true, yes.

Q. And so from 2007 forward you've been treating Canadian military members for PTSD, that's correct?

A. Yes.

Q. And did I hear you say that more patients have been coming for help since 2015/2016 for PTSD?

A. No, it's the other way around. So what I said was that between 2007 to 2015 there were ... a significantly large practice of my patient was PTSD patient. And as Afghanistan mission has ended and, you know, there's no longer deployment there, the last few years the patient profile is more of average population with some increases. I mean but not ... percentage-wise it's not as high as before in terms of PTSD patients.

Q. Okay. Thank you. So since 2015/2016 the number of military members that you've been treating for PTSD stemming from combat missions has decreased.

A. Yes.

Q. Okay. You indicated that you were recruited by the Forces in 2017 because they were anticipating that psychiatric services would be needed when soldiers would be coming back from combat missions in Afghanistan? Did I understand ...

A. 2007, yes.

Q. 2007.

A. But that's true.

Q. Yes. I appreciate that that was the military making forward steps to prepare for the return of the military members. Are you aware, Dr. Joshi, of what the Canadian Armed Forces did before these soldiers went into combat to help prepare them for the mental health piece of going to combat?

A. So I mean I cannot answer in great details. I could be wrong but I think before they go for deployment I think a member go through ... well, the acronym is called DAG. I don't know the detail. I can't ... I don't know the detail of what DAG would mean, but it's essentially screening of members to see if they are suitable to go for deployment, if there are any issues in their life that would prevent them from being deployed, like family issues, like any physical or mental health issues.

And typically, social worker or nurses would do that

assessment. And those people who are deemed to have, you know, some problems where they couldn't be deployed, as they call it, DAG (inaudible), so they are not allowed to be deployed. And then there's a pre-deployment screening that occurs. So there are certain things that were in place before deployment.

Q. Okay. And was that the case that the DAG screening and the pre-deployment screening would have been in place at the time that you started with the Canadian Forces in 2007?

A. So I joined in April 2007 and the rota for Afghanistan had left in February. So I was not very clear whether they were doing that before or not, but certainly, after I join I saw that it was being done on a regular basis.

Q. Okay. Would you have had an opportunity to look at, for example, Cpl. Desmond's DAG screening during the course of your ...

A. I don't remember. I don't recall looking at that.

Q. Okay. Thank you. Outside of those two things - the pre-deployment screening and the DAG screening - are you aware of anything else that the Canadian Armed Forces would have engaged in to prepare the soldiers for deployment before they left?

A. Again, from mental health perspective, I cannot really speak more, but I think as a unit I'm sure they're doing various

exercises and various seminars and, you know, preparing members for their deployment.

Q. Sure. Operationally, but in terms of mental ...

A. Correct.

Q. ... health, those are the two things that you understand would have been in place.

A. That's all I remember, yes.

Q. So those are like screening tools for the military. You're not aware of ... as I ... I don't want to put words in your mouth, but other than those screening tools are you aware of any counselling and training, mental health training, that members would actually receive outside of just being screened?

(14:30)

A. I think there used to be some seminars or there were seminars to kind of make people aware of different mental health issues and suicide risk or suicide-related issues but I'm not sure whether everybody got it before they left or whether ... I cannot recall that.

Q. Okay. So you believe that there may have been some seminars, educational seminars, but ...

A. Right.

Q. ... you're not sure when and how pervasive that would

have been through those members?

A. Correct.

Q. Okay, thank you. You were describing for Mr. Murray the multi-disciplinary approach for mental health treatment for members that you would have been part of, and certainly that was a multi-disciplinary approach with Cpl. Desmond.

A. Mm-hmm.

Q. My question is with respect to the psychosocial support. When there are issues with a member and their spouse or significant other, I think you referenced that there could be some resources if the member initiated. So, for example, if the member wanted to initiate couples counselling, then that would be a service that would be delivered through the mental health team that you were part of?

A. Yes.

Q. Okay. And if the member themselves did not want to initiate any kind of supports for their family members, for their spouse, would it be fair to say that any services that the member did initiate would be left to the spouse or the significant other to access on their own outside of the military umbrella?

A. I think there are services through Military Resource Centre for member's spouse to seek counselling. I think there

are other agencies in the community that they could access. Sometimes units could ask a member to seek help if the member is not ready. So there are other ways that spouses can access help in local community.

Q. Within the military system?

A. Within military system, I think through MFRC, but there may be outside military through their ... I don't know what that plan is called, but something like their insurance plan they are entitled for certain amount of sessions and ...

Q. Okay. And when you say ... sorry, when you say MFRC, you mean the Military Family Resource Centre?

A. Yes.

Q. Okay.

A. Yes.

Q. And a spouse, for example, could access mental health services through the Military Family Resource Centre but they would have to run that through insurance is that what your understanding is?

A. No, insurance would be separate program. So this is like I think seeking help for the spousal support, so to speak, regarding a member who might have mental health issues.

Q. Okay. Are you able to speak, Dr. Joshi, about the

types of help that would be provided through the Military Family Resource Centre to spouses or significant others of military members?

A. So, I think, there are a number of services but I cannot just recall, you know, all of them, but there are resources. There were also group sessions that we conducted for spouses of patients with PTSD. There is psychoeducational groups, they were held by a couple of my colleagues in the evenings for spouses of members with PTSD. Again, more or less similar fashion to psychoeducational group that Cpl. Desmond would have attended but more geared towards families.

Q. Okay. And families themselves could initiate attendance at that educational support group?

A. So the member would have to give us permission to contact the family member and sort of mention that I would like my wife or my significant family member to join and then they would be contacted and they can attend the group sessions. And they will run approximately two to three times a year. Like a course that is, you know, a few sessions running maybe in spring and fall, that kind of thing.

Q. Okay. So attendance at that course that you've just described would have to be initiated by the member giving

permission?

A. Member has to agree, so it's ...

Q. Agree. Yeah.

A. Yeah, because it's their privacy issues.

Q. Okay. I want to touch now briefly on a member's ability to access their medical records, Dr. Joshi, when they are releasing medically or otherwise from the military.

A. Mm-hmm.

Q. I understood your evidence to be if they had a family doctor to go to that the records ... the member would sign an authorization, those records would be forwarded to that family physician that would carry on their care. Is that accurate?

A. Yes.

Q. Okay. And if they did not have a family physician to follow their care upon release, the member could, still on their own, access their medical records by going to the medical record department and getting a printout?

A. Yes, they made a copy of their records.

Q. Okay. And do you have any sense, Dr. Joshi, of how long it takes them to access and get a copy of their records?

A. No, I'm not aware how long it takes, but I'm aware that they can go and get it.

DR. VINOD JOSHI, Cross-Examination by Ms. Miller

Q. Okay. The evidence that you gave with my friend, Mr. Murray, you talked about ... we were talking through the fall of 2013, and after a period of what seemed to be some stability for Cpl. Desmond he had a relapse and I think your language was he was very symptomatic, and that was following a racial incident in the workplace and also some ongoing but a flare-up of his marriage situation. I think his wife had said his wife had she wanted a divorce at that point.

A. Mm-hmm.

Q. And you had indicated that that sort of was a turning point in terms of understanding that this is going to be a lifelong issue for Cpl. Desmond. And I think your words were that there were life ... any major life situation would likely result in de-compensation for him. Is that an accurate characterization of what you had said about that?

A. Correct. Yes.

Q. Yes. Okay. And so from that I take, Dr. Joshi, that it was reasonable to expect into the future that his symptoms would ebb and flow, increase and decrease, depending on the nature of situational and life stressors that he would face?

A. Yes. I mean, yes, to a certain extent, yes.

Q. Okay. And that stressors involving things like a motor

vehicle accident, for example, would that be one of those life stressors that could cause his PTSD to flare and his symptoms to increase?

A. Possible.

Q. Okay. And certainly the end of his marriage, would that be something that you would expect would cause another episode in his life that would significantly ... could significantly increase his stress ... his symptoms?

A. Again possible, yes.

Q. Okay. Can you ... appreciating that we're going to hear from experts later on, but just from your perspective having treated PTSD for many years, can you talk to us a little bit about what ... there ... as I understand it there are different types of PTSD and one is called dissociative PTSD. Does that sound familiar to you? Can you explain ...

A. Yes.

Q. ... to us what that means "dissociative PTSD"?

A. So disassociation is where a person might lose track of reality and might start to behave as if the traumatic situation is recurring and might take those kind of actions as if they are in that situation again. So that what is considered dissociative episode, and the person who is experiencing all of those symptoms

would be kind of disassociating ...

Q. Okay.

A. ... sometime, so to speak.

Q. Okay. And what causes the disassociation to happen, is it further trauma?

A. Trauma or trigger or something that remind a member that sets certain memory circuits to get activated.

Q. Okay. Thank you, Dr. Joshi, those are my questions.

A. Thank you.

THE COURT: Mr. Rodgers?

CROSS-EXAMINATION BY MR. RODGERS

(14:39)

MR. RODGERS: Thank you, Your Honour. Good afternoon, Dr. Joshi, I'm Adam Rodgers.

A. Good afternoon.

Q. I represent the Estate of Cpl. Lionel Desmond, the personal representative. So I just have a few questions for you, Dr. Joshi.

I want to talk to you a little bit about PTSD. We've seen from your *CV* that you've got some ... you have some experience and some research experience in this field, certainly had some

experience with treating soldiers who have experienced PTSD. So I'd like to talk to you a little bit about this for a moment.

(14:40)

One of the things that I read when I read some of the literature is that the symptoms of PTSD can manifest themselves fairly soon sometimes after or often after the traumatic event. Is that a fair way to put things?

A. Yes. Some people it can start soon and some people might have a delayed response.

Q. I think that in terms of Cpl. Desmond and he didn't ask for help or didn't come in it seems to see you at least until three, four years after his service, after his combat experience. Do you see some concerns with that ... with that gap in time?

A. I mean, you know, sooner a person gets into treatment better it is but sometimes one person has to be ready to come in to treatment and sometimes it takes time to kind of realize how severe their problems are.

And, again, in this situation it was really more his wife who, you know, persuaded him to seek help. So it's not ideal but that's the reality, that people take longer time to seek help.

Q. Is that an uncommon feature in soldiers that come to see you, Dr. Joshi, is that somebody else either a spouse or a

friend has encouraged them, recommended them, notified, like, say you should go see somebody and that's what prompted them to come see you?

A. Yeah, that is common occurrence, yes.

Q. I wonder, Dr. Joshi, one of the things we're doing here is thinking of recommendations for changes in the future, and do you see anything in that area, in that space of when a soldier returns from active combat, rather perhaps than waiting for them to have ... to realize it themselves or to have it become so clear to somebody that's close to them that they're encouraged to come and seek help, that there's something structured for them when they return from combat to talk about that or talk to a professional such as yourself?

A. So I think that, you know, a lot of it is ... it's a multi-faceted thing, intervention. So some of it might involve more education, more awareness, more de-stigmatization of the PTSD. And a lot of members will have post-deployment screening, but many times a member may or may not accurately reflect their symptoms. So I think it's a multi-faceted intervention based on, you know, improving acceptance and seeking help seeking behaviour.

Q. Is there something about that post-deployment screening

that you could see being altered in order to remove some of that stigma or de-stigmatize it in some respect, you know, to say all right, well, you know, for a breakfast program everybody's getting breakfast so it doesn't matter, right. You're back from combat, everybody's going to go through this discussion with a psychiatrist, talk about their experiences and try to identify those symptoms. Would that be something you could see taking place?

A. I think again, every person is in different stages of their lives, so some members are absolutely not interested in seeking help. Sometime they might be more worried about their career and their promotion or their future. So each person kind of process information differently and come to their own kind of realization of seeking help.

It's very common that a member who might be identified as having these assessment and denying (inaudible - skip) to acknowledge that there's something wrong. So unless member is ready to seek help a lot of these interventions will facilitate but not completely reduce that duration of (inaudible - audio) that person has symptoms (inaudible - audio) manifest.

Q. So, Dr. Joshi, you're skipping a little bit there or the feed was. But what I take it is that you're saying some

soldiers may come back from combat and not be ready to talk about this and, in fact, forcing them to may cause them some difficulties. Is that a concern that you might have or what might be a concern there?

A. So each person is kind of reacting to their deployment differently and their stage of life is also different. So some of them might be concerned about, you know, not seeking help. Sometimes they might be concerned about if they start talking to somebody maybe things will get worse. Some members might be worried about losing job or losing their pride because sometime ... there's still some stigma in certain situations where a member might feel that they're letting their colleagues down, that they're weak or, you know, not good enough for their friends.

So all kinds of factor play into why someone seeks help early or why someone would delay seeking help. But you ... we see all kind of reasons. So some people will come within two, three weeks of symptom development while others will ... it might take years before they will seek help.

Q. Do you see a way of de-stigmatizing the PTSD experience? In some of the literature it seems to suggest, and I think you mentioned this earlier, is that exposure therapy seems

to be an effective treatment for PTSD, trauma-based exposure therapy. And so, in fact, talking about it isn't going to make it worse but will most likely make it better, would it not? Would you agree with that in terms of PTSD?

A. Sure, but it's the perception of the member who might not be aware about the research, right. So they might think that if they start opening the ... as they describe it they start to open a can of worms then things will get worse.

So a lot of members will try to contain it themselves and try to use their own internal strategies to see if they can go by for a longer period of time.

Q. So would you see that maybe it's counter-intuitive from the soldier's perspective, but would you see that as being potentially part of an education piece that would teach them well, you think that burying this and not talking about is the way to go, however, our research has shown this. Now whether you're experiencing PTSD or not we're going to tell you these things when you're back from combat as part of the post-deployment strategy?

A. So I think a lot of educational information sessions do occur from time to time, and I think members' awareness about PTSD is much more than now than it was, say 20, 30 years back.

So I think it's a process of change. So a lot of ... there's a lot of awareness of PTSD amongst those who don't have PTSD and ... but everybody kind of reacts individually to the information as well as means available for help.

Q. All right. Thank you, Doctor. And it strikes me from your testimony, that PTSD is certainly one if not the most prevalent condition that needs to be treated for soldiers returning from combat. Would that be a fair statement?

A. It's one of the common conditions, yes.

Q. And it's predictable as well. You say that after the heavy combat in Afghanistan, that was when you saw the most patients. That's when you were dealing with this the most among our soldiers, veterans. And so it strikes me that in future combat situations where the Canadian Armed Forces is taking part, that this is likely to recur. Would you agree?

A. I mean, again, this ... I mean, I'm sure the people who are managing future missions, combat missions, will ... they have learned from these experiences and factor that into their training or their mental health service, development, planning. So I'm sure, you know, they will learn lessons or understanding of this deployment to maybe improve services later.

Q. So, on that note, Dr. Joshi, you know, my friend, Ms.

Miller just asked you about pre-deployment and strategies that might be employed in that phase before a solder is sent to combat and I'm asking you now I guess about post-deployment and if there are recommendations or suggestions or at least areas of exploration that you would recommend in terms of people preparing for future combat missions?

A. I mean, post-deployment it's really a screening, education, de-stigmatization, availability of, you know, access so that people can access easily. So these are some of things that need to be, you know, developed more and more.

(14:50)

Q. It seems, Doctor, I'll switch topics just slightly here which is to ask you about Cpl. Desmond and his concussions. We've heard other ... We've seen other medical evidence that he suffered concussions but it appears in his first dealings with you, at least, that he didn't disclose that to you and we don't know why or I guess you don't know why he didn't disclose that to you, do you?

A. So, yeah, he didn't disclose any kind of head injury or injuries that might have got an IED blast injuries. Most of his trauma was witnessing experiences, so they were not involving IED blasts. Certainly he didn't disclose any neurological symptoms

at that time as well as any of the follow-up meetings. So, yes, the head injury aspect was not disclosed by him.

Q. Now it's possible certainly that he may not have appreciated how significant that may have been. It seems that he may not have even been fully aware of what PTSD was when he came to see you. But it also seems like you asked him about head injuries as well and it still wasn't disclosed.

I guess the question I'm leading to, Doctor, is had that ... had you known about concussions and post-concussion syndrome on Cpl. Desmond's part, might that have changed the way you approached his PTSD treatment?

A. I mean, if he had disclosed any head injury then certainly I would have factored that into his therapy; that is, maybe he might need therapy in a more slower pace or maybe he might need certain modification but certainly he didn't disclose any head injury to us so ...

Q. The broad ... from our review of the literature anyway, the broad strategies of treatment for PTSD alone or PTSD combined with traumatic brain injury or mild traumatic brain injury don't seem to diverge significantly. I mean, like you say you may treat them more slowly or talk to them differently but the overall strategies don't seem different. Is that your

methodology?

A. I think broad principle ... sorry, the broad principles will be the same but probably the therapist might have to modify the pace or maybe have smaller sessions rather than the long session and maybe give some break in between sessions during the sessions to kind of not burden member with focus and attention spans for a long period of time. So the information could have been ... could be broken into small pieces that can be given slowly.

Q. Yes. Another factor that seems like it may be important, and you mentioned it in your testimony, is the social environment for a solder coming back from combat experiencing PTSD and having that social support around them.

I wonder if you might comment on the benefits of having fellow soldiers who served in the same combat situation spending some more time together after combat as a decompression. I think they spend two or three days on a beach somewhere before they come back and then they all split up and go their separate ways.

Would you have any comment on the benefits perhaps of keeping that group together for a while after combat?

A. I mean, certainly there's a benefit to having some core group together, but again it depends on various circumstances, so

it's kind of hard to generalize answer to the question. But having a couple of close friends that you went with on a deployment being available for you to interact will be beneficial.

Q. Certainly whether it's within ... and sometimes circumstances may mean it's a phone call rather than an in-person visit or something along those lines. But would you be able to comment on the importance of having those friends around, those resources of somebody besides a mental health professional that you could just talk to?

A. I mean a follow-up support system is really important, so yes, it would be valuable.

Q. In the four years plus since this tragedy you've continued to treat soldiers with PTSD. And I want to ask you, Doctor, are there any new developments that you can tell us about over the last three or four years in terms of treatment strategies or anything else that has come along that you, you know, might have used with Cpl. Desmond or else it just may be of interest to us here at the Inquiry?

A. No, I think it's more validation of the treatment strategies in terms of therapy, that's what I'm more familiar with.

Q. Anecdotally, we hear some reports of the medical marijuana being somewhat effective. We've heard from Dr. Paul Smith and his clinic ...

A. Mm-hmm.

Q. ... in Fredericton. I'm not sure how aware you would be of his operations, his clinics there.

A. Yes, I am.

Q. What do you see from those in dealing with soldiers who are also going to those clinics to consume medical cannabis and, you know, hang out with their fellow soldiers? Have you seen good results from that at all?

A. So, I mean, this area needs a lot of research. And right now, a lot of members are doing it so they are kind of following the pattern, I think. Compared to 2015 the trend is changing slightly my observation.

So I don't personally prescribe medical marijuana, but I have seen a lot of members who might go in that direction. So I think the trend is slightly changing in terms of how much they use, the method of consumption, the percentage of THC versus CBD content that people are using. So I think there's that subtle shift that is occurring but I think obviously it needs, you know, research and validation.

Q. There seem to be other strategies that are coming along that are maybe more in the category of general mindfulness.

A. Mm-hmm.

Q. But, you know, exercise, certainly for anybody that's able to in terms of processing any mental issues that you may have going through. You know, would you ... is that something you recommend for your PTSD patients? The patients with PTSD, sorry.

A. So, yes, I mean mindfulness, exercise, any medication-based approach where a person focuses on their body, mind, their thoughts is all part of that comprehensive treatment. But a lot of it is ... cannot be ... it more like a self-help strategy. So you can ask someone that it's going to help you if you're engaging in hobbies or exercises, but it definitely requires that person to go and do it.

Q. The same with, for example, you know, nature exposure, nature therapy, spending time in the woods, you know, walking along trails, that sort of thing. Is that something you encourage as well to those that are able?

A. Again, it's part of the hobbies and kind of generally trying to do anything that helps you to feel relaxed and more connected with your surrounding is helpful.

DR. VINOD JOSHI, Cross-Examination by Mr. Rodgers

Q. Dr. Joshi, the United States military has some research on their web presence, and they talk about three general treatments for PTSD. One being cognitive processing therapy; the second being trauma-focussed exposure therapy; and the third is eye movement desensitization and reprocessing. We heard briefly about this in our earlier phase of the Inquiry, but is ... I want to ask you about this and is this something you use? What do you think of it? How effective is it? Sorry, the third one in particular, the eye movement desensitization and reprocessing.

A. So EMDR is one of the trauma-focussed therapy that is being used and EMDR, along with the cognitive processing therapy and prolonged exposure, are these three treatment therapy strategies that are used widely. So EMDR is used in our clinic by different therapists. There are a number of therapists in Fredericton/Oromocto area that are trained in EMDR.

So, ultimately when someone starts therapy, very soon the therapist and the patient would kind of come to some understanding which direction or which road to take in terms of treatment approach. So the therapist will usually then make recommendation that maybe we should try EMDR or we should try cognitive processing therapy and try to run that approach to see if that will be beneficial. So EMDR, there are a number of

clinicians in our clinic as well as, you know, in the community who can provide EMDR treatment.

(15:00)

Q. And you've found it ... have you had an opportunity to examine individual patients after they've experienced EMDR to make any determination as to its effectiveness?

A. It certainly seems to help many patients. Like any treatment, it doesn't work for everybody, but a substantive number of patient it seems to help them to process their trauma and they seem to be more at ease with their trauma after EMDR. So yes, it seems to be effective, but like any other treatment, it's not a hundred percent effective.

Q. All right. Thank you, Dr. Joshi. Those are the questions I have for you.

A. Thank you.

THE COURT: Mr. Hayne?

MR. HAYNE: No questions, Your Honour.

THE COURT: Thank you. Mr. MacKenzie?

MR. MACKENZIE: No questions, Your Honour.

THE COURT: Okay. Ms. Grant?

MS. GRANT: Thank you, Your Honour.

CROSS-EXAMINATION BY MS. GRANT

(15:01)

MS. GRANT: Just a sound mic check, Dr. Joshi. Can you hear me okay?

A. Yes, I do.

Q. Okay. Great. Dr. Joshi, my name is Melissa Grant and I represent the Attorney General of Canada and we're representing, along with my colleague, Lori Ward, the various Federal entities involved and including DND/CAF, Canadian Armed Forces.

Just a few more questions as we're approaching the end of the day. Thank you very much for your patience throughout the day. We really appreciate it.

Turning to Exhibit 183. Just the first exhibit that we looked at today. You can just pop that up and page 2. It's four pages. But just some general questions, Dr. Joshi. This was your initial meeting and assessment with Lionel Desmond. Correct?

A. Yes.

Q. And you had spoken earlier with Mr. Murray about that this report was a combination of what was reported to you by Lionel Desmond and then also other information that you had

gleaned. So I guess my question is, to what extent do you rely on the patient to provide you with accurate information?

A. I mean you would rely on patient for accurate information in a number of areas. There is certain information that only patient can provide. You know, it might include things like how they feel about their relationship, if they had any traumatic incidents in childhood. So there's certain personal detail that nobody else can know and person might provide, but there's other information that might be observational in nature or other people's interaction that could be taken into consideration. So it's a mixture of both.

Q. So he's reporting, you would agree, his own views of his situation, like his childhood experiences.

A. Correct, yes.

Q. And if you're writing that down in September 28th, 2011, you'd agree that that is an accurate representation of what Lionel Desmond would have said to you at that time.

A. Yes, because typically I would do my notes immediately after the session. So it would be done immediately.

Q. And in that report Mr. Desmond indicated that he had sustained severe physical and verbal abuse when he was a child. Is there any more detail about that that you recall discussing?

A. Essentially more with the involvement around the neighbourhood and the children, some of those that he mentioned about his life experiences growing up in his community.

Q. And did he mention how he felt he did at school?

A. I think he didn't do that well from academic perspective but I think he mentioned to get Grade 12 education. So kind of average, just on what ... below-average might be my sense.

Q. Thank you. Just moving on to ... well, it comes out of that report, and we've discussed it a little bit with various counsel. But there was no history of head injuries. You have said that a couple times. That's right.

A. Yes, I mean he never disclosed any head injury.

Q. And so one thing that we really haven't spoken about is an issue of later on after Lionel Desmond's treatment with you is complete he went to Ste. Anne. Are you familiar with that facility?

A. I'm familiar with the facility, yes.

Q. Okay. And one of the recommendations that came out of his stay there was that he should have a neuropsychological evaluation. So my question to you, Dr. Joshi, is, during your time when you treated Lionel Desmond and you saw him, you said,

over 30 times - and also in concert with Dr. Rogers - you'd agree that you didn't see that a neuropsychological evaluation was warranted.

A. No. So neuropsychological evaluation is done when there's a history of head injury and there's some evidence that there is some cognitive deficit, there is some difficulty in grasping information, memory, different concepts. So cumulatively, between myself and Dr. Rogers, we must have seen him over a period of three or three and a half years multiple times. At least it didn't occur to me that he had that kind of difficulty where he couldn't remember information. In fact, he responded to trauma processing in reasonable time.

So usually when people have head injury and they have cognitive deficit the psychotherapy becomes clear that they're having hard time in dealing with the trauma processing or getting understanding of the concepts or not able to generalize what they learn in therapy in the real life. So some of those thing we didn't notice.

So certainly, based on all this information, I think we didn't choose to go for neuropsychological assessment.

Q. So there weren't any, I guess, alarm bells raised in your mind.

A. At least from the information we had, we didn't ... or I didn't.

Q. And in looking at what you had ... I think you used the phrase "cognitive deficits" that you didn't see that. Was, to your knowledge, Lionel Desmond able to complete things like filling out paperwork? Was he able to do that?

A. He was able to do that. Sometime with anxiety he might need more time, but some of it could be related to avoidance and anxiety other than cognitive deficits.

Q. Maybe you could help us, and I guess I'll back up a little bit. Start with the concept that if somebody is a member of the Canadian Armed Forces their healthcare is provided by the Canadian Armed Forces. That's correct.

A. Yes.

Q. So if you had seen in Lionel Desmond, or perhaps in other people that you're treating, if you thought a neuropsychological evaluation was warranted is that something that can be done where you are Base Gagetown?

A. Yes, so we have a few clinicians ... a few psychologists who are experienced in doing neuropsychological assessment. So if anyone requires a neuropsychological assessment or testing, then we would refer them to those

clinicians for the evaluation, and we regularly do that kind of evaluation, you know, on an average ... I would say at least a couple of times a month (audio drop).

Q. Sorry, Dr. Joshi. You just cut out at the end. You said a couple of times a month and then we missed the rest.

A. Yes, so we will typically refer members for neuropsychological assessment wherever it's indicated.

Q. And can you just give us some idea? It's an assessment. So it's not treatment, per se, is that right?

A. Neuropsychological assessment, yes. So assessment will give guidance to sort of treatment strategies.

Q. So we lost the part after treatment strategies.

A. No, that's all I said.

(15:10)

Q. Okay. Sorry. Just catching up with you. So it could help inform clinicians on what treatments might be more effective, potentially.

A. Yes, and what strategies might work better and what strategy may not work better.

Q. So where you are ... and I appreciate you're in New Brunswick and we're here in Nova Scotia. do you have any idea how long it would typically take to obtain a neuropsychological

evaluation?

A. So currently, it could take anywhere from six to eight weeks to get ... for the patient to get to see the neuropsychologist who will do the assessment, and I'm giving you, like, a broad kind of ... broad range. And probably it might take three to four months to get the report back. So it's a very specialized testing. So it takes a couple of days to complete. So ... and there are very few people who do it. So we can get it done within ... you know, within, say, two or three months on an average.

Q. And so my understanding, they take a couple of days to complete. Is that right?

A. Yes.

Q. And if one were conducted in the CAF then there would not be a cost to the member.

A. No.

Q. But if, say, a civilian needed one of those, do you have any idea of the cost?

A. I think it's very expensive depending on who is doing it. It could be a few thousand dollars.

Q. And you don't have any idea of the wait times for something like that in Nova Scotia?

A. I'm not aware of wait time in Nova Scotia.

Q. Moving on to a different topic. You had talked earlier about a PTSD family support group.

A. Yes.

Q. And that was going on where you are at Base Gagetown?

A. Yes, we had a number of groups running during the year.

Q. And so that was for family members?

A. So it was predominantly for spouses but not exclusively. So most of the members, they would have a spouse. So ... but there would be certain situation where it could be a parent or it could be somebody else who might want to join the group.

Q. Okay. And at a certain point, we understand from the evidence that Lionel Desmond's mother came to live with him for a little bit. Did she ever contact you, or did Lionel Desmond ever contact you, to have her involved in that kind of a group?

A. I remember ... again, my memory is not very accurate, but I remember seeing and talking to her a couple of times and certainly Cpl. Desmond would be aware of that capacity. So if he wanted she could have then connected with that group.

Q. And did Mr. Desmond ever give his consent or mention you speaking to his sisters?

A. No, he didn't. He didn't mention me speaking to his sisters.

Q. Or his ... did he ever discuss his relationships with his sisters or his mom?

A. I think throughout he was more talking about his relationship with his wife and sometime it would be about his daughter. I think he was close with one of the sisters, from what he told me, more than others. So that was, I think ... so most of the time he was talking more about his wife and daughter.

Q. Okay. And a spouse would be the next of kin. Recognized as.

A. Yes, right.

Q. Dr. Joshi, we talked a fair amount with Mr. Murray about what I would call, I guess, the through-line of marital discord that was running, as you said, from the first meeting to the last. Is there anything that strikes, in your mind, that maybe we haven't discussed that was an issue between Mr. Desmond and his wife?

A. I think their relationship was back and forth. I mean it was ... and I think the long-distance relationship was major problem as well. But I think ... I don't think I'm going to add anything to what we've already discussed.

Q. Did he ever mention any issues getting along with his in-laws?

A. I think there was one incident - I don't remember exactly - where there was some sort of friction occurring between his in-laws and him. But just it was mentioned in passing. I think it was probably related to something around Christmastime interaction.

Q. And just a couple questions on the MELs, the Medical Employment Limitation. Just to clarify some language. I was a bit confused earlier. So I'm hoping you can help me with that. So we talked about temporary category or TCAT. We're doing okay with acronyms. In the military context there are usually a lot of them. So I think we're getting through that okay. But when we talked earlier about a personal weapon and that the Medical Employment Limitation would be that Lionel Desmond couldn't have a personal weapon. It's still the military context, correct?

A. Personal weapon in the military context ...

Q. Right.

A. ... as well as military weapons.

Q. So you know, for example, if I was a military police officer, as part of my job I would be issued a personal weapon. Is that right?

A. It's right, and I'm not sure what the clinician who made that note meant, whether he meant the personal weapon that a person could have when they are in the field or if they meant personal weapon that he had in his home. I didn't know what they implied.

Q. Right, so it's our understanding that in this context it's personal weapon in the military context versus the civilian firearms program. So that the military is not commenting on, in those documents, his ability to access weapons via the civilian program.

A. That's most probably true.

THE COURT: I just have a question, then. Doctor, if I might. Just a minute ago when you were asked that question in the context of personal weapons and you said it was in the military context and military weapons. So would it be your understanding that he was also not to possess military-issued weapons?

A. Yes, so if he's going on a field exercise and he's taking part in some kind of training, then he is not allowed to have that weapon under his MEL.

THE COURT: Thank you.

MS. GRANT: So it's just ... I guess just to back up a

little bit. You had said earlier it was a generic condition. So was that ... it's a common condition for someone who has a Medical Employment Limitation.

A. Yes.

Q. And you'd agree that it ... there's no pronouncement that it would mean that this person who has this limitation is necessarily going to be violent.

A. True.

Q. So it's our understanding that a personal weapon is a military weapon.

A. Yes, but I don't know what the person who wrote it meant.

Q. Okay. It's been suggested during the Inquiry that no one with a mental illness should be allowed to have a gun and I'm just wondering if you could perhaps comment on that.

A. So I think, you know, it's a complex issue. So I think mental disorder is a very broad term. So it will have condition which are very minor and transient in nature to very serious mental illness including various psychotic condition. And many mental condition might improve with treatment and person could have years of healthy, active life, and some conditions are chronic where a person is always symptomatic.

There's also kind of societal policy and public policy kind of thing as to who should have a gun and who shouldn't. So I think it's a complex issue.

Q. Thank you, Dr. Joshi, and just turning to a couple more questions about PTSD. You obviously have extensive experience treating members with PTSD. Ms. Miller asked you earlier about dissociative PTSD. Is that something that you saw in Lionel Desmond, or had those ... or could he discern reality during your time with him? Was there anything that suggested to you that he couldn't tell reality from ... fact from fiction?

(15:20)

A. So when ... during my involvement with him, and certainly my assessment of him, it appeared that he had very few dissociative experiences and this subsided with treatment. And ... but again, these symptoms can fluctuate. So it's possible that some other time he could get into more dissociative episode. But substantive part of his involvement with us, they seemed to be under control.

Q. And just generally, PTSD and ... just for our education purposes. It's ... I think you'd agree that in the general population about nine percent of people have a PTSD diagnosis?

A. That's an average kind of consensus. Approximate

prevalence.

Q. And that a PTSD diagnosis is actually more prevalent in women?

A. That's true. In general population, yes.

Q. In the general population. And having a PTSD diagnosis in and of itself does not make a person statistically more likely to commit acts of violence, would you agree with that?

A. So there is higher chance of committing violence but it does not mean that everybody who has PTSD is prone to violence. So it's slightly higher risk compared to average population but it doesn't mean it's hundred percent.

Q. Is there a difference between self-harm versus homicidal ideation?

A. So homicidal ideation would be rare compared to suicidal or self-harm ideation in a person with PTSD.

Q. You've ... the word "multifactorial" is, I guess, a word I've heard that you describe this sort of situation where something could potentially lead to ... you said a rare event like homicide. Is that your understanding that it's a multifactorial issue?

A. Yes.

Q. And in your career where you've treated numerous people

with PTSD, this particular situation that we're talking about during this Inquiry, is that the only time you've experienced something like this as a treating professional?

A. Yes, so this is the worst kind of experience I had in terms of one of my ex-patient committing, you know, family and himself. So this is the worst situation I've faced in my life.

Q. Can you ... or would you agree with the statement that more treatment is not always better?

A. So PTSD treatment is balanced between building up resiliency versus, you know, exposure is the treatment. So you had to expose person to situations that they're avoiding. So if you want to do that then you had to enable member to face the situation that they have been avoiding. So sometime you had to back off and see if person is able to manage, you know, after a certain period of therapy to see if they can handle their life events and situations or not. So whether they can generalize the skills that they learn during the therapy in their real life.

Q. And I guess in a similar vein one sort of, I guess, theme we've heard from you today is that everybody is different, that you have to ... I guess maybe you'd agree with the statement that there's no one-size-fits-all approach to a person with PTSD.

A. There are broad strokes of treatment, but certainly,

that has to be calibrated to individual need.

Q. So would you agree that it's not unusual that sometimes it takes time to find what works best for an individual patient?

A. That's true.

Q. And in some cases in-patient treatment may not be viewed as superior to out-patient treatment. Maybe they respond better in one situation or another.

A. So in-patient treatment has to be used judiciously when it's needed, especially when someone is suicidal or potentially violent. But long-term in-patient treatment may or may not be helpful in the long run. Certainly, it can help in certain situation, but it has to be calibrated to person's need.

Q. And I think you'd agree with me that a person with PTSD may expect I guess what I'd call a new normal, that maybe they don't go back to the person that they were before.

A. I mean when someone is seen for the first time your treatment goal is to improve quality of life and functioning to as close to their pre-PTSD days as possible, but during the course of treatment sometime it becomes apparent that some people are not going to be that perfectly back to their pre-PTSD functioning. And sometime half-glass-full is as good as treatment can achieve because ... just because of the intensity

and range of symptoms.

Q. Just a couple questions on I guess what I will refer to as involuntarily holds. There was ...

A. Sorry, what? I didn't hear.

Q. Involuntarily ... sorry, involuntarily holds. So there was some suggestion - I read in a media report, actually - about Lionel Desmond being allowed to leave Ste. Anne, and I guess I would ask you about the concept of autonomy in a patient's care. So would you agree that that includes the right to make potentially poor decisions?

A. So typically, when person is about to leave a hospital or a treatment facility, if person is perceived to be imminent danger to themself or other due to a mental illness, then that person can be detained in the facility by using **Mental Health Act**. If the person is in the community, the community psychiatrist or doctor could use what is called Form 1 of the **Mental Health Act**, which allows 72 hours of assessment.

But if there's no concern about imminent danger, then there's a ... then person have personal autonomy to take decisions. So if person says, I'm not willing to cooperate with the treatment, and the treating doctor feel that they are not imminent risk to themself or others, then, generally speaking,

person were able to discharge themself or cease the treatment.

Q. And you never had any experiences with Lionel Desmond where you thought he posed an imminent risk of harm to others, himself or others?

A. No. I mean when he had suicidal ideas or when he had thoughts about any violence it was ideas. It was not imminent idea that was felt that he is going to act immediately on it. So there was no reason to consider him for involuntary admission to hospital. And this is more when he was under our care.

Q. Just a couple more questions on the issue of medical records. I think you noted that sometimes it takes a while for veterans who are transitioning if they don't ... either they don't know where they're going or they are going to a place where it's difficult to find a family doctor, is that right?

A. Yes.

Q. And in terms of completing a form to obtain medical records, would you agree that the member's consent is a necessary step?

A. Yes. So if we are referring person to OSI clinic or any clinician in community member has to give consent for their medical record to be released to the receiving clinical physician and so that is needed. So the person on the other end of pathway

person ... the member can go to medical record and get copy of their medical record and take it wherever they are accessing treatment.

Q. And when you talked earlier about sending the records to the OSI clinic ... we've been using that word "OSI". So it's "operational stress injury", is that right?

A. Yes, yes.

Q. And those clinics are sort of scattered throughout Canada. Is that right?

A. Yes.

Q. And to your understanding, who attends those clinics or who is able to seek treatment at an OSI clinic?

(15:30)

A. So retired military personnel. I understand RCMP officers and other front line can access. But in my practice, it's mainly the retired military personnel would go there.

Q. And do you have ... and there ... my understanding is that their provincial facilities, but they're funded by Veterans Affairs Canada. Is that your understanding as well?

A. Yes.

Q. And just on the issue of medical marijuana, I think you noted that one of the problems you saw is that people were given

large prescriptions of medical marijuana and then had no follow-up for, you know, it could be up to a year. Is that right?

A. So there are a lot of these online pharmacies around and doctors ... members are getting prescriptions and very limited follow-up appointments. So if a product is prescribed as a medicine, then the person who is prescribing should be following it up to make sure that dose is accurate and there's no adverse effect and the treatment is, you know, going in the right direction. So a lot of times, we were seeing that.

Q. And where you are, did you see peer pressure in terms of members wanting other members to use medical marijuana?

A. I think that was prevalent during those days, yes.

Q. And that was not that ... medical marijuana, a prescription for medical marijuana, is not something that was covered by CAF. Correct?

A. No, no.

Q. And in what was then known as the JPSU and is now a transition unit, that's not a treatment unit. Correct?

A. I mean it's kind of a treatment, in a sense, work-related. So if the member who is getting released or who is on permanent category who is not able to do their regular work might get posting there, where they might, if they're getting released,

might look at what future holds for them. So they might use the opportunity to maybe get a placement in civilian side to try out a different placement to see what exactly they like to do after they're out or it might be a placement within the base in a different capacity, different kind of work to kind of see if that will attract them as a future career. So I think it's a mixture of being away from regular duty and kind of preparing for transition.

Q. Okay. Aptly named then. Just one other phrase that was a little bit confusing to me. You were referring earlier to a case manager? And it's my understanding that there was a case manager who was a Canadian Armed Forces case manager. Is that right?

A. Yes, yes.

Q. Okay.

A. So we have several case managers in the clinic who will help members transitioning.

Q. Okay. And the reason I'm asking that question is because Lionel Desmond also had a VAC case manager. So I just wanted it to be clear that there are, in fact, two case managers.

A. Yes.

Q. Okay.

THE COURT: So Ms. Grant, I'm going to ask a question.

MS. GRANT: Mm-hmm.

THE COURT: If I might. Dr. Joshi, I've seen it referred to as a "nurse case manager". Is that the same as the CAF case manager that you're referring to or is a nurse case manager somebody different?

A. So I think a lot of case managers are nurses by qualification. So it might be that they are referring to themselves as nurse case manager. So I think, if I'm correct, many of the case manager colleagues have nursing background.

THE COURT: All right, thank you.

MS. GRANT: And just finally, Dr. Joshi, Lionel Desmond was seeing a multidisciplinary team which you've talked about today, and I think you referred to Dr. Rogers as being a very experienced therapist. Is that right?

A. Yes. I mean at one time she was our senior most psychologist in the clinic and she was clinical lead for a while. So she's very experienced and very respected psychologist.

Q. So in this sort of area where Lionel Desmond has access to a psychiatrist, psychologist, social worker, addictions counsellor, is this area where you come to access these services, is it sort of like a one-stop shop for someone who is in the CAF?

A. So we have this mental health clinic where all of us are situated. So many of us ... so we basically work across each other, so yes. There might be some situations where we might refer for a particular service outside the clinic but majority of people might be seeing clinicians in the clinic.

Q. And I guess this is, I appreciate, perhaps a self-serving question, but did you feel as though Lionel Desmond was in good hands when he was receiving treatment with the CAF?

A. I think especially with Dr. Rogers. I mean she was one of the most experienced psychologists with a lot of experience, yes.

Q. Thank you, Dr. Joshi. Those are all my questions.

A. Thank you.

THE COURT: Mr. Murray, do you have any follow-up questions?

MR. MURRAY: No, Your Honour.

THE COURT: All right, thank you.

EXAMINATION BY THE COURT

(15:36)

THE COURT: Dr. Joshi, I have just a couple of questions I want to ask, if I might. I believe it was Ms. Grant had asked

you a question about discussions you may have had with Mr. Desmond in relation to his family and I know that in Exhibit 183 there was a comment that he said he had four sisters. One of them is a nurse with whom he has regular contacts. He had very limited contact with the other three sisters. And then he denied any family history of mental illness, suicide, psychosis or addictions. I think that's the recollection that you had of the discussion about his family?

A. Yes.

Q. Is that correct?

A. Yes.

Q. All right, thank you. You were asked a question and it related to, it was in the context of suicidal ideation.

A. Mm-hmm.

Q. And I understood you to say that although you might not ask a question directly, such as, Are you suicidal, but you would have a discussion that would touch on a variety of things and you would look at the answers to see, for instance, if the person was forward thinking? Is that ... did I understand you correctly?

A. So it will be a combination of various questions. So the interview would go more like a conversational manner. So if someone is saying that, I'm not feeling well, then you would ask

very explicit question, that, Are you suicidal? Do you have suicidal thoughts, ideas, any plans? But if someone comes and says they are doing very well and there's no concern and so the intensity of question might be different based on how the interview is processing, what kind of non-verbal cues you are getting. So you would modulate your question depending on the responses you're getting, but it could be a detailed question about suicide or it could be a member could say, I'm doing well. I don't have any suicidal thoughts. And you might move on to some other topic.

Q. The concept of a person being forward thinking.

A. Mm-hmm.

Q. Does that assist you in making some determination as to whether the person might present some suicidal risk, either imminently or into the future if they are, you know, forward looking into that future?

A. So if someone is giving a reasonably good plan about future, what they plan to do, what they hope to achieve in the near future, then it kind of suggests, along with other information that you have that, you know, they are not looking at ending life or they are maybe thinking about various things that they might want to do in the future. So you will give some

weight to that to your decision-making, or your kind of internal understanding of clinical judgment.

Q. Okay. So I'm going to ask you a question and I'm going to put some facts into my question that I recall here. And I don't know if you are aware of the circumstances leading up to the homicides and the suicide that took place on January the 3rd or not, but generally, the sequence of circumstances that I want to bring to your attention are this. You know that in, I think it was early December 2016, Lionel Desmond had a meeting with a psychiatrist, Dr. Slayter.

A. Mm-hmm.

(15:40)

Q. And Dr. Slayter made certain observations of Cpl. Desmond at that time and wanted to see Cpl. Desmond later in December. And I think it may have been around the 16th or the 18th, or maybe a little later, that he gave him an appointment and he missed that appointment.

A. Mm-hmm.

Q. It turns out that there was an event at the ... there was a circumstance that required him to be at the school to do ... to look after his daughter, as I recall. He went to the hospital. So he missed that appointment in December.

A. Mm-hmm.

Q. Then on New Year's Eve, Mr. Desmond had been out with his wife and others and the vehicle that he was driving went off the road. There was some minor damage to it, if much damage at all. He was home. He became somewhat unconsolable and upset over what had happened and left the house and went to the St. Martha's Hospital, spent the night in the Emergency Department, and I believe that while he was there, among other things, he had his phone and I think a breakdown of the phone logs show that he was on the internet looking at a variety of different things and generally at goods, I guess, as much as anything.

He was released the next day and the doctor who released him was confident that he could be released at that time, but one of the things he asked him to do, I believe, was to reschedule the appointment that he had missed with Dr. Slayter, and he indicated that he was going to make an appointment with his therapist as well. He said he would do those two things.

The next day, which was January the 3rd he, in fact, rebooked the appointment that he'd missed in December for January the 18th, I believe it was. That was in the afternoon. He went in and did that. He also called his therapist and spoke to his therapist on the phone for about 25 minutes or thereabouts that

afternoon as he said he would. And sometime after that - that was also in the afternoon - at 4:00, we know that he went into a gun shop and was in there for about 20 minutes, bought a rifle, ammunition, and by 6:00, everyone was dead.

A. Mmm.

Q. So there's some behaviours there that would suggest to me that he was planning on a future up until at least 6:00 when he was in the residence.

Now do all those pieces fit together for you?

A. That's kind of complex question. Certainly, during the time, his involvement with me, I mean, there was ... he never kind of talked about any violent thoughts towards his family members. In fact, he was very concerned about his family members many times.

So I think this switch from accessing his clinicians to going to gun shop for buying weapons seems ... it seems like a big shift in his mental thought process. So I mean it's hard to kind of give an impression about what might have been happening at that point.

Q. Mmm. All right, thank you.

Well, here's another question I'm going to ask you and if you don't think you can or if you would rather not venture an

answer to it, then I'm going to invite you to tell me that. All right?

A. Mm-hmm.

Q. My question comes from an answer that you gave, or an observation that you were making when you were talking about treatment and treatment going to quality of life. And some people may never return to the quality of life that they had before they, in this case, went to war and came back with PTSD and go through treatment regimes. And your comment was that a glass half full may be as good as you get.

A. Mm-hmm.

Q. So are there, for some people ... does that mean that for some people that a glass a quarter full is as good as they get? Does it mean for some people a glass one-sixth full is as good as they get? And does it also mean that for some people, the glass will be empty and remain that way?

A. So I think, I mean glass half full is kind of expression, kind of figure of speech. And in some sense, that would suggest that, you know, some people may not make full recovery, although our goal of treatment might be to help people to make as good recovery as possible, but still there are certain conditions where someone might remain symptomatic and they might

be better in some domain of life and they might not be better in some other domains of life. So that would be my kind of explanation or answer.

Q. All right. Well, as I said, I'm not going to force you into an answer of what a glass empty might look like.

So Dr. Joshi, I know that to be here today took time and I know that you spent time being interviewed by counsel and preparing for today. I know you've looked at documents and I know that there's been considerable effort put into your preparation to be able to answer questions and assist us today, and I want to thank you for your time. It's appreciated.

A. Thank you.

Q. Thank you.

A. Thank you.

Q. We can cut the feed to Dr. Joshi then. Thank you.

WITNESS WITHDREW (15:47 hrs.)

THE COURT: Tomorrow we have Dr. Rogers.

MR. MURRAY: Yes, Your Honour.

THE COURT: All right. So we'll adjourn for the afternoon and I'm just going to ask counsel to remain for a couple of minutes. Thank you.

COURT CLOSED (15:48 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

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March 14, 2021