

CANADA

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF THE  
*FATALITY INVESTIGATIONS ACT*

S.N.S. 2001, c. 31

**THE DESMOND FATALITY INQUIRY**

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**TRANSCRIPT**

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

**PLACE HEARD:** Port Hawkesbury, Nova Scotia

**DATE HEARD:** February 25, 2021

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1 February 25, 2021

2 COURT OPENED (09:29 HRS.)

3

4 THE COURT: Good morning, everyone. I understand we  
5 have Dr. Murgatroyd and Mr. Canty with us here this morning.  
6 Can you hear me, gentlemen? Good morning.

7 DR. MURGATROYD: Good morning.

8 THE COURT: All right. Thank you.

9 MR. CANTY: Good morning, My Lord.

10 THE COURT: Good morning. In the normal course of  
11 events, Dr. Murgatroyd, you would be sworn before you testify.  
12 Ms. Acker is going to give you some options with regard to that  
13 in a moment here if you like.

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1 **DR. MATHIEU MURGATROYD, sworn, testified:**

2 **THE COURT:** All right. Thank you. Mr. Russell?

3 **MR. RUSSELL:** Thank you, Your Honour.

4

5 **DIRECT EXAMINATION**

6

7 **MR. RUSSELL:** Good morning, Dr. Murgatroyd.

8 **A.** Good morning.

9 **Q.** So I just ... before we begin I just want to say try  
10 to speak as sort of ... a bit louder than usual, and if you have  
11 any sort of ... if there's at any point you can't hear me, or we  
12 cut out, just let us know. We can make arrangements with Judge  
13 Zimmer to redirect things. And if at any point during your  
14 evidence you need a break for whatever reason just signal to me.  
15 Just indicate that you'd like a five-minute break or so and I'm  
16 sure the judge will accommodate you.

17 **A.** Okay.

18 **Q.** So Doctor, I wonder if we could begin. Could you  
19 state your full name for the Court?

20 **A.** Mathieu Murgatroyd.

21 **Q.** And I understand that ...

22 **A.** Do you want my ...

1 Q. Go ahead ...

2 A. My middle name, Thomas. Mathieu Thomas Murgatroyd.

3 Q. Okay, and Doctor, I understand that you're a clinical  
4 psychologist?

5 A. Yes.

6 Q. And how long have you been ...

7 A. Yes.

8 Q. ... a clinical psychologist?

9 A. I've been a licensed psychologist since November 2014.

10 Q. I'm going to ask a very basic sort of question. What  
11 is the difference between a psychologist and a clinical  
12 psychologist?

13 A. Well, a clinical psychologist would have a specialty  
14 in, you know, clinical practice. "Psychologist" is a broad  
15 term, right? It may mean ... you know, it could be an academic.  
16 It could be a researcher. But the distinction of a psychologist  
17 is a licensed professional. So there would be a license. But a  
18 clinical psychologist would be a ... somebody that practises  
19 clinical psychology, therapy, assessment, things of that nature.

20 **EXHIBIT 243 - CURRICULUM VITAE OF DR. MATHIEU MURGATROYD**

21 Q. So Doctor, I guess we'll start with your CV. It's  
22 marked as Exhibit 243, and you would have ...

**DR. MATHIEU MURGATROYD, Direct Examination**

1           **A.**    Mm-hmm.

2           **Q.**    ... a hard copy, I believe, in front of you as well?

3           **A.**    Yes.

4           **Q.**    I guess if we could start. There's quite a bit in  
5 here but I'm primarily interested in starting with just your  
6 education. So if you could take us through your education. I  
7 believe there were three levels of education that went into your  
8 doctorate?

9           **A.**    Yeah, sure. So the first would be the undergrad,  
10 Bachelors of Arts, specialization in psychology from, you know,  
11 2003 to 2007 at the Universite de Moncton. You know, following  
12 that I was thinking that I might go into the research side of  
13 things, and my supervisor at the time ... you know, we were  
14 looking at different options. He had done some postgraduate  
15 studies in England and so, you know, it was a bit ambitious but,  
16 you know, I, you know, gave it a go and did a psychological  
17 research methods, you know, a one-year program at Keele  
18 University. So this was not a clinical program. It was  
19 research methods.

20           You know, during that year I realized that, you know,  
21 research wasn't for me. Statistics, you know, weren't for me.  
22 So I made the decision that I wanted to change course. I

**DR. MATHIEU MURGATROYD, Direct Examination**

1 finished the program. I took a year off. I worked at a company  
2 called Alternative Residences here in Moncton. You know, my  
3 first real taste of, you know, working with individuals with  
4 mental health challenges. Residential homes. And then I joined  
5 the doctorate program at Universite de Moncton in 2009.

6 **Q.** And you completed your doctorate in clinical  
7 psychology in 2013?

8 **A.** Yes.

9 **Q.** So I'm wondering if we could look at ... which would  
10 be page 2 of your CV. I'm primarily sort of ...

11 **A.** Mm-hmm.

12 **Q.** ... interested in your post-doctorate employment as it  
13 relates to clinical psychology.

14 **A.** Mm-hmm.

15 **Q.** So I guess if ... so I understand you did a residency  
16 between September 2013 and August of 2014?

17 **A.** Yes.

18 **Q.** And where was that residency ...

19 **A.** Yes, so ...

20 **Q.** ... and what did it involve?

21 **A.** So that was at the work recovery program, which is  
22 part of WorkSafe New Brunswick in Grand Bay-Westfield, you know,

**DR. MATHIEU MURGATROYD, Direct Examination**

1 just near Saint John, New Brunswick. So for the most part it's  
2 working with individuals who have physical injuries. So chronic  
3 pain issues. And these individuals have, for whatever reason,  
4 been unable to rehabilitate locally.

5 So these were individuals from across the Province of New  
6 Brunswick who would be coming to this program, an intensive  
7 program, you know, throughout the week days, staying at hotels  
8 locally, and come in every day almost as if they're coming in  
9 for work and then, weekends, go back to their hometown.

10 So a lot of the ... it's a multi-disciplinary team effort,  
11 you know, working with physios, OTs, you know, physicians, and  
12 there was a component of ... this was my first taste with PTSD.  
13 There was component of traumatic psychological injuries. So  
14 working ... I had the opportunity to work with a correctional  
15 officer, conservation officer, a firefighter and so in the  
16 assessment and treatment of PTSD.

17 I will note that at that time I hadn't yet had specialized  
18 training in PTSD, but I was under the supervision of Dr. Jane  
19 Walsh, who had a lot of experience in that setting. She had  
20 worked there for a number of years.

21 Q. Okay, and from there, once you finished your residency  
22 you ...

**DR. MATHIEU MURGATROYD, Direct Examination**

1           **A.**    Mm-hmm.

2           **Q.**    If we look to sort of page 1 of your CV you have  
3   clinical psychologist, OSI clinic, Horizon Health Network. I  
4   understand this to be the ...

5           **A.**    Yes.

6           **Q.**    The Horizon Health Network is basically the OSI clinic  
7   in New Brunswick?

8           **A.**    Yes, yes.

9           **Q.**    And so ...

10          **A.**    So you know ... yeah, sorry.

11          **Q.**    And so you have indicated here it was between 2014 and  
12   2019 that you were a clinical psychologist there. I wonder if  
13   you could take us through just generally what exactly your  
14   position was and what your role was within the OSI clinic  
15   structure.

16          **A.**    Right, so we had four psychologists there at the time  
17   at the clinic, and we probably will get into this a little bit  
18   later maybe. You know, but just the operational kind of  
19   procedures, right? But the psychologists will provide both  
20   assessment and treatment for veterans and RCMP, which are the  
21   individuals that we see at the OSI clinic.

22          Most of the work would be the treatment portion. We get

**DR. MATHIEU MURGATROYD, Direct Examination**

1 two types of referrals at the OSI clinic. You know, assessment  
2 for treatment and assessment for disability. And this ... we  
3 probably will get into this a little bit later, I imagine.  
4 Assessment for treatment would be individuals who already have  
5 an OSI diagnosis coming in to the clinic. And so those would go  
6 directly to therapy ... a wait list after the intake with a  
7 nurse. And there may also be the recommendation to meet with a  
8 psychiatrist.

9 **(09:40)**

10 The assessment for disabilities. As I mentioned, the other  
11 type of referrals. Those would sometimes come to psychologists  
12 where a comprehensive assessment for disability would be  
13 completed with various tools that we use to help with the  
14 diagnostic process. So these could take up to 15, 20 hours  
15 depending on, you know ... of meeting with the individual,  
16 meeting with the partner if that's applicable, appropriate, and  
17 so that was also part of the work.

18 As I mentioned, the treatment portion was a bit part of the  
19 work, individuals who already have an OSI or, you know, once the  
20 diagnosis is given to a client who came in as an assessment for  
21 disability, if it's, you know ... yes, sorry?

22 **Q.** So were you ... you were involved in the treatment

**DR. MATHIEU MURGATROYD, Direct Examination**

1 aspect of a client ...

2 **A.** Mm-hmm.

3 **Q.** ... that would be referred to the client. Would you  
4 also be involved in the diagnosis of that client?

5 **A.** For ... just for the referrals that came in for an  
6 assessment for disability.

7 **Q.** Okay.

8 **A.** So that's the distinction, which ... I don't have  
9 statistics in front of me, but I'd say probably 15 percent of  
10 clients' referrals were assessment for disability. The bulk  
11 were assessment for treatments, i.e., individuals who already  
12 had an OSI diagnosis.

13 **Q.** And we'll get into the operations of the clinic a  
14 little bit later ...

15 **A.** Yeah.

16 **Q.** ... but at this point over the course of those years  
17 between 2014 and 2019 are you able to sort of estimate, I guess,  
18 what occupations do various clients come from in terms of their  
19 backgrounds? Who's involved with the OSI clinic?

20 **A.** There's a variety of trades. Again, I don't have the  
21 statistics in front of me, but we tended to see a lot of  
22 veterans who were in the combat trades, right? Combat soldiers.

**DR. MATHIEU MURGATROYD, Direct Examination**

1 We would see engineers. We saw individuals that were in the  
2 specialized forces. And we also saw individuals who were  
3 members of the RCMP.

4 Q. And in terms of your caseload between those years.

5 A. Mm-hmm.

6 Q. If you were to estimate ... and I'm not ... estimate.  
7 I'm not going to hold you to an exact figure, but what  
8 percentage of those would come from a military occupational  
9 background?

10 A. Yeah, I would say, you know, probably close to 90  
11 percent. Yeah.

12 Q. So we'll move on to ... I understand you changed  
13 positions. You still stayed affiliated with the Horizon Health  
14 Network, but between 2019 and present you are now a clinical  
15 psychologist in the addiction and mental health services. What  
16 is the difference there? What was the distinction in the  
17 positions?

18 A. Well, in a community mental health setting ... and  
19 maybe I should have added that in there. So I'm in a community  
20 mental health setting. You know, we're looking at a general  
21 population in individuals that may have ... it may be a little  
22 bit more of a variety in terms of the presentation, and

**DR. MATHIEU MURGATROYD, Direct Examination**

1 certainly backgrounds, right? You know, so what we're ... it's  
2 less specialized as is the case at the OSI clinic given the  
3 clientele. Yeah.

4 **Q.** So if I'm understanding this correctly, your new  
5 position deals with clients that have a mental health diagnosis  
6 in the general population as opposed to directly connected to an  
7 operational stress injury?

8 **A.** Sure. I would say they don't need a diagnosis. They  
9 can reach out for help if they're ... regardless of diagnosis.

10 **Q.** So ...

11 **A.** And it's covered. It's covered through Medicare. So  
12 it is, you know, a service to the public. You know, we tend to  
13 see, you know, individuals that may have more of a, you know,  
14 disadvantaged, you know, background that may not have insurance  
15 to go into the private setting where there would be costs. So  
16 it's a public service.

17 **Q.** So this is going to be important for the context of  
18 your evidence. So you would ... is it fair to say that you  
19 spent the majority of your career dealing with military clients  
20 with operational stress injuries?

21 **A.** Yes, because I was there five years.

22 **Q.** And I wonder if you could ... we've heard evidence on

**DR. MATHIEU MURGATROYD, Direct Examination**

1 this, but I think it's fair to sort of revisit the concept.

2 What is an operational stress injury?

3       **A.** So an OSI is any constant psychological problem  
4 resulting from operational duties performed, you know, either  
5 while serving in the Canadian Forces or as a member of the RCMP.  
6 You know, it describes a broad range of problems which can  
7 include a diagnosed mental health condition such as post-  
8 traumatic stress disorder, depression, anxiety. So that would  
9 be, you know, kind of a quick definition.

10       **Q.** And we're going to go back to your CV. So in your  
11 period of time in treating members of the military for  
12 operational stress injuries, I understand that you had some  
13 detailed background and courses which may have been helpful that  
14 we put into practice. If we could turn to page 6 of your CV.  
15 And I'm going to go through a number of select courses that  
16 you've taken and I'm wondering if you could explain to us what  
17 those courses were, ultimately - in general terms - and how they  
18 relate to your practice in treating operational stress injuries  
19 as a clinical psychologist operating at that clinic.

20       So I guess February of 2010 it says Applied Suicide  
21 Intervention Skills Training. What is that and how did you  
22 apply that in your practice? I just want to make sure we're on

**DR. MATHIEU MURGATROYD, Direct Examination**

1 the same (inaudible - audio drop).

2       **A.** Yeah, so you know, that was a training at the time I  
3 was a student, right? And it's a two-day program I'm seeing  
4 there where, you know, you're learning tools on how to, you  
5 know, assess suicide risk, right? The risk factors. You know,  
6 and in terms of the application, right? It's a big part of our  
7 work. There's no doubt about that in terms of looking at, you  
8 know, risk factors, as I mentioned.

9       You're looking at the ideation of thoughts themselves in  
10 terms of, you know, are they fleeting thoughts? Are they  
11 deliberate? Are they ruminative? You know, we're looking at,  
12 Is there a plan in place, right? The when, where, how. You  
13 know, are ... is there access to means? We're looking at risk  
14 factors that are, you know, internal, environmental, right? So  
15 internal being, you know, are there mental health challenges?  
16 You know, is there substance abuse? Environmental risk factors  
17 may be, you know, are there legal issues? Are there financial  
18 issues, right?

19       So we're kind of looking at a host of different factors,  
20 and we're looking at protective factors, right? Both again with  
21 ... internally, externally, right? Is the individual religious?  
22 Is the individual ... you know, what are the values? And you

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1 know, protective factors also, you know, the people around,  
2 right? You know, children, family, pets, you know, jobs.

3 So you know, with that, you know, we are, you know,  
4 assessing risk, and of course there is a judgment in there,  
5 judgment call, and we have a duty to ... you know, if we judge  
6 that there is significant risk, right? In terms of, There is a  
7 plan ... there is a plan where access means we may need to act  
8 on that, yeah. So that was ...

9 **Q.** Sorry, go ahead. Sorry. So ...

10 **A.** No, that's about it, yeah.

11 **Q.** Okay, so the next course I want to highlight was 2012.  
12 It says, The Psychophysiology and Treatment of PTSD. So what  
13 ...

14 **A.** Yeah.

15 **Q.** What was that and how does it apply to your practice  
16 as a clinical psychologist in an OSI setting?

17 **A.** Yeah, and that one, I'll be honest with you, is not  
18 one that I did use, right? So I'll go based on memory. It had  
19 a lot to do with the ... more of the sensations that are ...  
20 that we often see in PTSD and, you know, the idea was to try and  
21 ... you know, rather and speaking and talking about the  
22 traumatic event the focus is a little bit more on the sensory

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1 experience, right?

2 **(09:50)**

3 And so it's not something that I use in my practice,  
4 because once I arrived at the OSI clinic, you know, I learned  
5 about the, you know, three gold-standard approaches with ... and  
6 you know, which we'll get into in a few moments.

7 **Q.** Okay, so moving on to Prolonged Exposure Therapy for  
8 PTSD. Before I ask you what that is and how it applies in your  
9 practice as within the OSI structure is this a course that if a  
10 clinical psychologist in the community is treating, say, victims  
11 in a sexual assault case would they necessarily always have this  
12 particular training?

13 **A.** I'm not sure I understand the question. Would they  
14 have access? Would they ...

15 **Q.** I guess in the context of Prolonged Exposure Therapy  
16 for PTSD and its application to a military veteran would a  
17 clinical practitioner, a psychologist in the community,  
18 necessarily have the same training as it relates to applying  
19 this to a military veteran?

20 **A.** Would they have ... if they're ... if they don't have  
21 that training you mean?

22 **Q.** Yeah. Do they always have that training out of the

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1 gate or no?

2       **A.** No, this is something that, you know, you need to ...  
3 you know, it needs to be, you know, paid for. In other words,  
4 it's not something that you get in training at a university  
5 level. To my knowledge. You know, unless ... you know, there  
6 is usually a fee ... a charge involved. I don't know. Is that  
7 what you're wondering?

8       **Q.** I guess ... I guess if we could ... I'll ask what it  
9 is first and then we'll move from there. So what is Prolonged  
10 Exposure Therapy for PTSD?

11       **A.** So it is a treatment approach that is specific to  
12 treating PTSD. It is an exposure-based approach with ... where  
13 you're kind of targeting avoidance and other symptoms. And  
14 there are two main interventions that we are ... that are  
15 included in that approach. It would be exposure to *in vivo* ...  
16 to situational triggers. We call that *in vivo* exposure. It's a  
17 bit of jargon. But situations in real life that have been  
18 avoided, you know, due to the traumatic event.

19       So it's gradually exposing the individual to these  
20 situational triggers, because these situations are important,  
21 you know, for the individual to kind of get back to. And of  
22 course ... right, we're tapping into all sorts of different

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1 situations that may be again connected to the trauma, be it  
2 smells, be it, you know, sounds, be it tastes.

3 And so what's also interesting with that portion of the  
4 therapy is that sometimes it also be situations that have been,  
5 you know ... that the individual has disconnected from over time  
6 that may be important for them to engage in but because of the  
7 PTSD they're unable to engage in them. So it might be more kind  
8 of like pastimes or hobbies.

9 And then the second component is the imaginal exposure  
10 which is a structured technique that we're doing in the office  
11 together which is revisiting the trauma memory. Usually we are  
12 going with the index trauma which usually is considered the most  
13 difficult trauma in cases where the individual has multiple  
14 traumas and there is a structured way of doing that.

15 And the idea with, you know, both the ... both approaches  
16 is that a desensitization is happening, right, so the distress  
17 over time, you know, is reduced with the repetition.

18 Q. So I guess my question is, if a clinical psychologist  
19 is trained in Prolonged Exposure Therapy for PTSD is there  
20 anything unique about applying that therapy to military veterans  
21 as opposed to just being a generalist? So a clinical  
22 psychologist could say, Look, I have this training, full-on

**DR. MATHIEU MURGATROYD, Direct Examination**

1 Exposure Therapy, I can see any client ...

2 **A.** Mm-hmm.

3 **Q.** ... and it doesn't really matter, there isn't any  
4 unique experience that I need or unique approach that I have to  
5 take.

6 **A.** Mm-hmm. Well, okay. If the indiv- ... if the  
7 psychologist has training I think that it would be appropriate  
8 for them to use that approach. Certainly, you know, clinicians,  
9 psychologists, social workers, psychiatrists - working at an  
10 OSI, you know, have more experience, you know, working with  
11 military veterans and RCMP because that's what we do. So  
12 there's a benefit there.

13 But if you have the training I wouldn't see a problem with  
14 applying, you know, that approach to an individual with PTSD.

15 **Q.** So what is the benefit of that experience and being  
16 part of the OSI and ... what is the benefit of that?

17 **A.** Well, it's that contact, right? And just, you know,  
18 kind of knowing the lingo, knowing, you know, some ... just, you  
19 know, some of the ... when it comes to just the military ... how  
20 do you call that? Just the background and where they're coming  
21 from. The culture. That's the word I was looking for, right?

22 So you know, having ... working solely with individuals

**DR. MATHIEU MURGATROYD, Direct Examination**

1 that are coming from the military, you have a little bit more of  
2 that flavour whereas, you know, if you're in a private setting  
3 you might not get that. Unless you're specializing and that,  
4 you know, you're meeting, you know, that type of clientele  
5 solely.

6 And certainly in areas like Fredericton, right, close to  
7 the base you have those types of private psychologists. So I  
8 don't know if you know what I mean.

9 Q. Yeah. I'm certainly not trying to, you know, portray  
10 one category of clinical psychologists as necessarily superior  
11 to the other. I'm just trying to get the concept and idea of  
12 the advantages of a military veteran suffering from PTSD or  
13 major depressive ... depression seeing someone that has the  
14 background of training with military veterans as opposed to a  
15 clinician, a psychologist, generally in the community who has a  
16 caseload ...

17 A. Mm-hmm.

18 Q. ... that involves victims of sexual assault and has  
19 never seen a veteran before. So ...

20 A. Sure, yeah, and I can add to that, you know, just the  
21 ... you know, the other clinicians, the other professionals that  
22 are present there, right? If the ... if I'm working with a

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1 psychiatrist and the individual is working with a psychiatrist,  
2 right, there's a collaboration, right? Which you might not  
3 necessarily get with another private psychologist, yeah.

4 Q. Okay.

5 A. We're all in the same place.

6 Q. And we will get into that. So moving next to  
7 Cognitive Processing Therapy for PTSD. What is that and how  
8 have you used that in your practice with the OSI clinic?

9 A. Yeah. So CPT is essentially CBT-specific to the  
10 disorder of PTSD, right? So as is the case with, you know, CBT,  
11 Cognitive Behavioural Therapy. You know, you're really looking  
12 for ... looking at ... for automatic thoughts, you know,  
13 distorted, you know, cognitions, beliefs that maintain PTSD,  
14 right? So we kind of call those stop points.

15 And you know, in the approach, right? You know, one  
16 intervention which is sometimes, I believe, optional is writing  
17 a detailed account of the traumatic event, right? And you get  
18 an opportunity there to ... you know, the individual can ...  
19 there's exposure that's happening there. There's a  
20 desensitization.

21 But you're also able to with ... collaboratively with the  
22 client to highlight, maybe, some stop points and some, you know

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1 ... and stop points being like, you know ... you know, some of  
2 the stop points that we encounter in our work is, you know,  
3 thoughts like ... or beliefs like, you know, the world is  
4 completely dangerous, you know, no one can be trusted, right?

5 **(10:00)**

6 And there's an emphasis on, you know, areas of safety,  
7 trust, power, control, esteem, and intimacy which, you know, are  
8 ... in PTSD there are symptoms that, you know ... kind of  
9 connected to that, right? I'll be honest, my ... the approach  
10 that was my go-to was Prolonged Exposure Therapy. I did use CPT  
11 as well. A lot of folks that we saw did the group ... the CPT  
12 group on base. So they had already completed that. So that was  
13 one of the reasons why I tended to go with the Prolonged  
14 Exposure, and maybe just a preference.

15 **Q.** And again, would you have a similar sort of  
16 perspective and position as it relates to ... is there an  
17 advantage to a military member that has a clinical psychologist  
18 who has the experience in applying that technique to veterans as  
19 opposed to just in the general population?

20 **A.** Yeah, I think I'd stick with the same response. Yeah.

21 **Q.** Cannabis and PTSD. It says, Existing evidence ...

22 **A.** Mm-hmm.

**DR. MATHIEU MURGATROYD, Direct Examination**

1           **Q.**   ... and clinical considerations. Tell us a little bit  
2 about that in your experience.

3           **A.**   Right. You know, I know we're going to get into this  
4 a little bit more. I ... this, if I recall, was ... and my  
5 recollection is vague on this. You know, we ... this was  
6 something that we looked at a lot, you know, as a clinic,  
7 certainly, because it was kind of a hot topic. And you know, I  
8 know that we'll be talking about this some more.

9           It's looking at the evidence, and I know that research is  
10 still limited, right? You know, we're looking at the benefits,  
11 you know, and where the benefits are with the, you know,  
12 different, you know, conditions and PTSD, right? So there are  
13 still limits to that. Beyond that, I don't have too much of a  
14 recollection on the talk.

15          **Q.**   Okay, so I guess if we move to the bottom of page 5.  
16 It's the last of three courses. I sort of wanted to just draw  
17 out some general information before we get into specifics later  
18 on.

19          **A.**   Mm-hmm.

20          **Q.**   Dialectical Behaviour Therapy. What is that and have  
21 you used that in your practice?

22          **A.**   So DBT. I'm trying to ... you know, so this would

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1 have been a two- ... and so this, you know, wouldn't have been a  
2 comprehensive training. I'll just kind of put that out there.  
3 Two hours. But when I was interning as a ... at the doctoral  
4 level, I did have the opportunity to sit in on a group program,  
5 a DBT program. DBT is an approach that is typically used for  
6 the treatment of Borderline Personality Disorder, which is, you  
7 know, something that we would have used ... which is something  
8 that we would have seen at the OSI from time to time.

9 Q. So just ...

10 A. At the ...

11 Q. ... generally, what is Borderline Personality  
12 Disorder?

13 A. Borderline Personality Disorder is a mental health  
14 disorder. We sometimes call it kind of ... acts as two  
15 disorders because it's a personality disorder. You know, some  
16 of the symptoms that ... and when we're talking about  
17 personality disorder usually we're talking about something  
18 that's more kind of longstanding, you know? Given that ... and  
19 more ... you know, given that it's a personality disorder.

20 So usually, you know, we're talking about, in terms of the  
21 symptoms, fluctuating moods, you know? You know, in terms of,  
22 you know, Bipolar Disorder we usually kind of think about more

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1 kind of episodic and kind of like phases with Bipolar Disorder  
2 in the fluctuation. You know, we're talking kind of like, you  
3 know, quick, fast-moving.

4 So there can be, you know, interpersonal conflict, right?  
5 Stormy relationships, a history of abandonment issues and  
6 concerns around abandonment. There can be reckless behaviours,  
7 suicidality, self-harm that we see in Borderline Personality.  
8 There can be dissociation. And so those are some of the  
9 features that we see with Borderline Personality Disorder.

10 **Q.** And on the same page there is a course listed there,  
11 Making Heads or Tails of Concussions. So I take it you have  
12 some experience and familiarity with veterans suffering from  
13 concussions in a clinical ... in your clinical practice?

14 **A.** Yeah, and you know, once again that would have been a  
15 clinical workshop where we would have looked at, you know, some  
16 of the conditions, you know, some of those symptoms associated  
17 with some of these conditions. You know, looking a little bit  
18 at kind of teasing apart, because there is often an overlap when  
19 it comes to other types of mental health concerns.

20 With the trainers, somebody that is in the Horizon system  
21 would have given us that training. We didn't ... I'll just add  
22 we ... you know, there was no ... maybe looking at some of the

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1 tools. But there was no ... we weren't practising these tools.  
2 That wasn't that type of more comprehensive training where  
3 typically you're practising, you know, these tools. But yes,  
4 you know, it was helpful.

5 **Q.** And the last one. It says, An Evidence-Based ... at  
6 the very top of page 5 in 2018. An Evidence-Based Cognitive  
7 Behavioural Therapy (CBTI) Approach to Insomnia for those in the  
8 Armed Forces. That seems pretty specific in terms of a therapy  
9 here directly to members of the Armed Forces as it relates to  
10 sleep. What is that?

11 **A.** Right, so yes, that was a training that was offered  
12 for clinicians across the OSI network, and it is an evidence-  
13 based as the title suggests, I think, the gold standard when it  
14 comes to treating insomnia. And so there are parts of it that  
15 is CBT but also parts of it that is really behavioural and, you  
16 know, kind of sleep schedule, right? And you know, wanting to  
17 improve, you know, the individual's sleep to improve, you know,  
18 the condition of insomnia, right?

19 So it's looking at, you know, sticking to a, you know,  
20 standard, you know, wake time, standard, you know, bedtime, you  
21 know, and, you know, getting up when, you know, you're unable to  
22 sleep. You know, if you're tossing and turning. Because it's

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1 not time to fall asleep. You know, so a lot of education  
2 around, you know, the sleep-wake systems, the circadian rhythm,  
3 and really having that opportunity, you know, once you do the  
4 psycho-education, to really stick to a ... kind of like a, you  
5 know, a specific bedtime. And you know, really based on sleep  
6 and that tiredness, right? Because there is a distinction  
7 between feeling tired versus sleepiness, which is a stronger  
8 physiological process.

9 So I haven't had an opportunity because ... to apply that  
10 training because, you know, insomnia is like a ... pure insomnia  
11 is not something that I've worked with. But certainly, some of  
12 the strategies that I would have seen in the training have been  
13 helpful, certainly.

14 **Q.** So is it fair to say that in your employment as a  
15 clinical psychologist in an OSI clinic that you were offered  
16 very unique and specialized courses as it relates to treating  
17 certain members in mind, such as military veterans?

18 **A.** Yes, there's a ... there is a lot of opportunity to  
19 ... for training, yes.

20 **Q.** And when you attend these courses do you see many  
21 clinical psychologists in the general population and community  
22 outside of an OSI clinic taking these same courses?

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1 (10:10)

2 A. I think they have limited spaces for ... you know, I'm  
3 thinking, you know, some of the ones that we focussed on. So  
4 most of the individuals that were there were from the OSI  
5 network and I think there were, you know, maybe a few more  
6 spaces for other clinicians. But yes, for the most part we're  
7 talking about across the OSI network.

8 Q. So mostly sort of in-house OSI clinicians that are  
9 taking these specialized courses as it relates to military  
10 veterans?

11 A. Yes. Yes.

12 Q. And that leads me sort of to my next question. From a  
13 clinical psychologist's perspective, is treating an operational  
14 stress injury in a military veteran any different than treating  
15 a mental health disorder of someone in the general population?  
16 I know that's a broad question, but I'm just looking again for a  
17 general answer and we can narrow it as we go along.

18 A. Sure, yeah. You know, one of the distinctions that,  
19 you know, jumps out to me is the transition out of the military  
20 into civilian life, right? So that is something that would be  
21 distinct from, you know, more of a, you know, what I'm doing now  
22 for example, right? Because, you know, you have the mental

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1 health condition - if it's PTSD, if it's depression - but on top  
2 of that you've got a significant transition that can lead to,  
3 you know, a significant adjustment, right?

4 So you know, for these individuals they've been there five,  
5 ten, 15, 30 years and that's what they've known, you know? And  
6 so the camaraderie, the structure, the routine and kind of going  
7 ... getting out of that into a civilian life, right, can present  
8 some challenges, right? So that is one, you know, distinction,  
9 and a significant one.

10 Q. So when you're applying a treatment for a mili- ... a  
11 treatment, I guess, program ... structure put in place ...

12 A. Mm-hmm.

13 Q. ... for a military veteran would you say you're at a  
14 bit of an advantage compared to a clinical psychologist in the  
15 community in that you're able to sort of understand these  
16 concepts of the transition that you've talked about in  
17 structuring a treatment plan?

18 A. Yeah, that ... I would agree with that point, right?  
19 Just given, you know, that we're familiar with the culture, you  
20 know, and we're ... you know, there is that expectation that  
21 there may be that difficult transition. It's not always the  
22 case but that there may be that tran- ... difficult transition,

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1 and you know, we're kind of prepared for that in the treatment  
2 that we offer.

3 Q. I want to get your perspective on something that  
4 applies in terms of four different categories. So generally I  
5 want you to be able to speak to ... if you could identify any  
6 sort of issues, challenges, or barriers a clinical psychologist  
7 would have in treating military-based clients in the following  
8 sort of areas. So first any issues, challenges, or barriers you  
9 see that are unique to building a therapeutic alliance with a  
10 military veteran as opposed to sort of a general ...

11 A. Okay.

12 Q. ... population.

13 A. Certainly, there is a level of guardedness that we  
14 see, I'd say, fairly regularly. We can see that in the general  
15 population, but I think in my experience you would see a little  
16 bit more with the clientele at the OSI. And sometimes that can  
17 interfere with, you know, the therapeutic alliance early on and  
18 treatment. So just kind of like a guardedness, maybe unwilling  
19 to share, you know, some of the information and, you know, that  
20 can also be part of the PTSD presentation as well, right?

21 Sometimes there's a sense of pride, if you will, right?

22 In, you know, dismissing, you know, certain issues and not

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1 wanting to kind of get into that. So sometimes that can be part  
2 of the challenge early on, right, in getting, you know,  
3 substantial information.

4 **Q.** I guess we should back up even a little bit. In a ...  
5 what is therapeutic alliance and why is it important when  
6 treating clients?

7 **A.** Right, so a therapeutic alliance is ... I guess we  
8 call that a concept. Or you know, it's part of the treatment  
9 process. It is that connection between the therapist and the  
10 individual. So you know, the working relationship, right? And  
11 you know, clinically speaking, you know, it is really important,  
12 you know, if the therapeutic alliance is not there. If there's  
13 not a trust, you know, between, you know ... especially, you  
14 know, with the individual with a therapist, it's going to be  
15 difficult to be successful, right?

16 Because there's a power differential that we sometimes see,  
17 right, and between the therapist and the individual just because  
18 of the nature of the relationship. So we're really trying to,  
19 you know, kind of connect with the client and build that  
20 therapeutic alliance so that they're able to open up and trust  
21 and move on with treatment.

22 **Q.** And in your opinion, is a therapeutic alliance

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1 necessary before you even sort of get out of the gate when  
2 applying treatment?

3 **A.** I'd say it's significant. It is really important,  
4 yes.

5 **Q.** So I guess again with the same question but in a  
6 different context. Any issues, challenges, or barriers as it  
7 relates to members of the military for operational stress  
8 injuries compared to the general population when you are  
9 identifying treatment goals with the client?

10 **A.** Mm-hmm. As I mentioned earlier ... and you know, not  
11 to just kind of repeat myself. If there is that guardedness, if  
12 there is, you know, that, you know, sense of pride, you know,  
13 that sense of, you know, kind of diminish ... you know, wanting  
14 to dismiss certain symptoms, certain ... you know, the  
15 presentation. They may not be willing to, you know, set certain  
16 goals, right?

17 So there may be some of that, but if we're able to kind of  
18 get through those early stages, right? And kind of build that  
19 therapeutic alliance, you know, goal-setting is usually  
20 something that we're able to do, and I wouldn't see it as being,  
21 you know, too much of a challenge, you know, once we've  
22 established kind of that rapport.

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1           **Q.**    What are some of the unique challenges that you're  
2    faced with when it comes to the actual treatment of a military  
3    veteran as compared to, again, a civilian in the general  
4    population with the same underlying disorder or condition?

5           **A.**    Mm-hmm. Yeah, yeah, and you know, at the risk of  
6    sounding like a broken record, that transition, you know ...  
7    right, is ... again is something that ... you know, in my  
8    experience, when there are adjustment issues, right? Of, you  
9    know, the transition to civilian life and kind of struggling  
10   with that adjustment, you know, and maybe not having the  
11   supports in place. And because you're used to having, maybe,  
12   all the supports in one place and now, you know, you're kind of  
13   transitioning out. At a deeper level in terms of that lack of  
14   purpose, lack of meaning, you know, that you had, right, that  
15   that can kind of, you know, impact.

16           So we're talking about, you know, sometimes individuals  
17   that have several mental health issues, challenges, you know, be  
18   it, you know, PTSD, depression. Kind of just the adjustment as  
19   I mentioned and, you know, which can lead to poor coping  
20   strategies. And all of these can interfere, you know, with the  
21   process, right?

22           So I think that that would be, again, a distinction between

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1 military individuals, veterans, versus the general population.

2       **Q.** In terms of ... it's important ... I guess it's a fair  
3 statement to say that it's important for any patient or client  
4 that's dealing with a mental health issue to have a continuity  
5 of care as they go between various departments and see various  
6 professionals. Is there anything unique or challenging as it  
7 relates to the continuity of care when it applies to military  
8 veterans?

9       **(10:20)**

10       **A.** You know, I think that, you know, given that the  
11 mental health challenges that are sometimes seem complex in  
12 nature. Again I'll repeat myself. Just this ... they're at a  
13 crossroads for a lot of them, right? And so what is this next  
14 chapter going to be about?

15       And so the continuity of care is important so that they  
16 have these supports in place, you know, as they're going through  
17 these changes, these adjustments that can lead to significant  
18 stresses, right? So yes, you know, very important.

19       **Q.** As a clinical psychologist who is experienced treating  
20 operational stress injury clients in an OSI clinic setting, and  
21 also those in the community, would you say that there is an  
22 aspect of a sub-specialty in a clinical psychologist who treats

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1 a military veteran for an OSI?

2       **A.** Mm-hmm. Yeah, you know, just give the specialized  
3 training, as we kind of talked about earlier. The ... just that  
4 familiarity with the culture, the multi-disciplinary setup that  
5 we have at the OSI, right? So again ... and it's not as if I,  
6 you know, completed a doctorate, you know, with that specialty,  
7 but broadly speaking, sub-specialty, I would agree to that. You  
8 know, just given the nature of the folks that we work with.

9       **Q.** So we're going to get into the particulars of your  
10 experience with Lionel Desmond but knowing ...

11       **A.** Mm-hmm.

12       **Q.** ... what you know about his underlying mental health  
13 struggles, his conditions, his external stressors, and this  
14 concept of he's going to see a therapist in the community. So  
15 you're told Lionel Desmond is going to see a clinical  
16 psychologist. Is there anything that you would like to know  
17 about the clinical psychologist that would suggest maybe they  
18 are best suited for him in order to achieve the best success?

19       **A.** Yeah, I'd be interested in, you know, getting a sense  
20 of ... the psychologist's experience, right, training, some  
21 background, you know, things of that nature.

22       **Q.** And what sort of training what you think that a

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1 clinical psychologist ought to have if they were going to treat  
2 someone such as Lionel Desmond?

3 **A.** So you know, if we're ... you know, we talked a little  
4 bit about the gold standards when it comes to treating PTSD. So  
5 Prolonged Exposure Therapy, CPT, EMDR. Certainly, you ...  
6 training with, you know, maybe, CBT, which is, you know ... a  
7 lot of us get that training at the university level of that sort  
8 of work. So that sort of training.

9 **Q.** Is there sort of ... in your experience, is there sort  
10 of aspects of maybe not every clinical psychologist is  
11 necessarily the person for a military veteran with a certain  
12 diagnosis? Is there certain ones that maybe are more suited  
13 depending on the type of trauma, the level of trauma?

14 **A.** I think it kind of comes back to the training and then  
15 sometimes, you know, it does occur where it was just the  
16 therapeutic alliance. Or you know, it's not there for whatever  
17 reason, I don't know, it's just kind of like ... in terms of the  
18 personalities not aligning. You know, that may happen, and if a  
19 transfer is applicable, then that ... we can ... that that is  
20 sometimes done.

21 **Q.** So I'm going to ask you a few questions about the New  
22 Brunswick OSI clinic. If you could just turn generally to page

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1 19 of the exhibit. It would be Exhibit 244.

2 **EXHIBIT P-000244 - NB OSI CLINIC - FULL FILE**

3 I notice, Your Honour, the video seems to freeze up a  
4 little bit but the audio seems to be fine. Did you wish me to  
5 sort of continue to see how it goes?

6 **THE COURT:** Yes, as long as we've got the audio. The  
7 video may self-correct so ...

8 **MR. RUSSELL:** Okay. So I'm going to ask you some general  
9 questions about the OSI clinic in New Brunswick. What types of  
10 ... and you've touched on this a bit earlier. What types of  
11 clients are treated at the OSI clinic in New Brunswick? From  
12 what backgrounds?

13 **A.** Yeah, so it would be a member ... it would be veterans  
14 of the Canadian Forces, Canadian Force members, as it is  
15 mentioned there. I think in some instances it ... we ... I  
16 don't think I ever met with an active member, but I think in  
17 some circumstances that happened and then eligible RCMP ...  
18 active RCMP members.

19 At one point family members as well. We also had a couple  
20 ... couples counselling, social workers offering that service.

21 **Q.** So clearly, the fact that we have an OSI clinic in  
22 Nova Scotia and previous to that and still existing there's an

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1 OSI clinic in New Brunswick ...

2 **A.** Mm-hmm.

3 **Q.** Tells us that there's a reason behind why they exist.

4 So what types of services are offered at an OSI clinic that are  
5 not offered sort of in the general community that a military  
6 veteran can't necessarily readily access?

7 **A.** As we kind of talked about earlier, there would be  
8 that kind of like the collaborative approach, you know, having  
9 all these services at ... in one setting, in one clinic, right?  
10 If they were working with a social worker or a clinical  
11 psychologist in tandem with psychiatrists, we've got nurses as  
12 well that have that familiarity and that training working with  
13 individuals with OSIs.

14 So you have that familiarity. You have the training to  
15 offer that specialized treatment, right? And both assessment  
16 and therapy.

17 **Q.** So why is it an advantage to a military veteran to  
18 have a collaborative approach at the OSI clinic as approached to  
19 a patched system in the community of a group of different  
20 practitioners that don't necessarily communicate with each  
21 other?

22 **A.** Yeah. I think you kind of hit it there and you kind

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1 of ... you know, the communication is, you know, important,  
2 right, between the health practitioners. And so if you're all  
3 in the same place that's beneficial.

4 **Q.** So the OSI clinic, as it's structured, is it an in-  
5 patient, out-patient, or can it be a hybrid of services?

6 **A.** So the OSI in Fredericton is an out-patient service.

7 **Q.** So how are referrals received to the OSI clinic in New  
8 Brunswick? Who do they come from?

9 **A.** So they can come directly from the base. We also  
10 receive referrals from Veteran Affairs, case managers at Veteran  
11 Affairs.

12 **Q.** So do you get ... can you get a referral to the OSI  
13 clinic in New Brunswick from a family doctor in the community?

14 **A.** So yeah, that's a good question. My understanding and  
15 my recollection is that, no, he would have to go through Veteran  
16 Affairs. So the GP, you know, would have to be educated or  
17 instructed to make that recommendation to Veteran Affairs and  
18 then Veteran Affairs will relay that information. I know that  
19 our wonderful admin support would often field those types of  
20 questions and clarify.

21 **Q.** So a veteran that's in need of services at the OSI  
22 clinic is dependent on what entity to make the referral or

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1 entities?

2       **A.** Yeah, so as I mentioned, either it's a direct referral  
3 from the treatment team at the base or a case manager at Veteran  
4 Affairs. Or you know, a ... somebody working at Veteran Affairs  
5 that can relay that referral.

6 **(10:30)**

7       **Q.** So when a referral is made to the OSI clinic is there  
8 a general sort of intake assessment that's done each time?

9       **A.** Yes. That's, you know, the way I remember it. You  
10 know, the first contact's really would be intake nurse. Right?  
11 And that may be over the phone, that may be in person, it may be  
12 both. And it's getting a sense of the referral. Right? You  
13 know, if it's coming from the base, from a psychiatrist, it's  
14 looking at that. And, of course, it's assessing needs during  
15 that intake. And once that's done, the intake nurse will make a  
16 recommendation in terms of what service is based on those needs.

17       **Q.** So is it ... is ... involvement with the OSI Clinic in  
18 New Brunswick, is it always for a set duration or can it vary,  
19 depending on the services that are needed and the struggles or  
20 the extent to which the client is dealing with their mental  
21 health?

22       **A.** Yeah. I think it's a case by case. I think there's

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1 variability there, you know, depending on the needs and the  
2 presentation. You know, there's an expectation, you know ...  
3 and we have these discussions early on that ... in which it's  
4 not meant to be forever, right, but we are, you know ... you  
5 know, we're working towards the goals and we're working towards,  
6 you know, recovery, if you will.

7 **Q.** In terms of your experience, what's the longest you've  
8 seen a military veteran stay affiliated with the OSI Clinic in  
9 New Brunswick?

10 **A.** And, look, everybody is a little bit different, right,  
11 and sometimes there's a need ... you know, if I may just kind of  
12 give examples, right, where ... you know, once the trauma-  
13 focused therapy is done let's say with an individual, I may  
14 close that individual to therapy but the individual might  
15 continue seeing the psychiatrist. So that individual is still  
16 open to the clinic, but that individual might only be attending  
17 appointments every three months or whatever the agreement is  
18 with the psychiatrist. And this individual might not have a  
19 family doctor, right, so in this extreme case, right, the file  
20 might be open for a longer period of time. Does that make  
21 sense?

22 **Q.** Yes. Yes, it does. So in your time with the OSI

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1 Clinic in New Brunswick, are you able to estimate how many  
2 military veterans you would have treated within a course of a  
3 year or in total?

4 **A.** Yeah. You know, early on obviously there was a  
5 progression, if you will, right, as a new member of the team. I  
6 would say probably roughly around 100 there, all told, give or  
7 take.

8 **Q.** Are you able to comment on how many veterans may  
9 currently be at the OSI Clinic in New Brunswick or maybe from  
10 any given year to year?

11 **A.** Sorry, I don't have any statistics in front of me.

12 **Q.** So I guess I'm going to go back to this question a  
13 little bit more. Well, before I do, ultimately what's the aim  
14 ... you're a clinical psychologist in an OSI setting and you're  
15 treating a military veteran. What is your aim in terms of the  
16 treatment? Where do you want to end up and where do you want  
17 the client to end up?

18 **A.** Yeah. And that's really based on the client's goals,  
19 right, and based on kind of like the conceptualization that  
20 we've kind of worked on collaboratively. You know, of course a  
21 lot of them it's, you know, if there is a PTSD, well, it's  
22 working towards treating that PTSD so that the client can get

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1 back to ... .. some of them even talk about them becoming their  
2 own mini therapist in the community and that they're able to  
3 manage their symptoms. They're able to work through them, you  
4 know, whenever they may show up. They're better able to cope so  
5 that they're able to move on with their lives with whatever the  
6 next chapter looks like for them.

7 You know, some of them are looking to retrain, you know,  
8 and maybe have another career. You know, some of them, it might  
9 be closer to retirement and they're just kind of looking to get  
10 back to life. They're looking to get back to, you know,  
11 activities, things that they've lost along the way, that the  
12 mental health challenge is just kind of getting in the way. So  
13 that's the ultimate goal, if that makes sense. But it's really  
14 based on a case by case and the individual that I've got in  
15 front of me.

16 Q. You talked about the advantages of the OSI to a  
17 military veteran in the sense of there's a collaborative care  
18 between social worker, psychiatrist, psychologist, nurses, all  
19 within and under sort of one umbrella compared to sort of a  
20 patch system that's out there in the province general healthcare  
21 system. Can you give examples, in your experience, as to what  
22 is an advantage to a military veteran? What's an example of an

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1 advantage of being treated inhouse at the OSI as opposed to  
2 maybe ... I'll use the phrase "floating around" in the province  
3 accessing services here and there?

4       **A.** As I said, you know, the ... having all the services,  
5 you know, in one facility, in some way, you know, we can even  
6 argue that they're kind of used to that, you know, because of,  
7 you know, what they would have experienced in the military.  
8 Oftentimes, just kind of like they get a lot of services onsite.  
9 Right? So they're used to that. In a collaborative nature in  
10 that communication ... you know, we're meeting regularly. You  
11 know, if I need to meet with a psychiatrist, I ask for that time  
12 and we're able to kind of ... we're kind of able to discuss that  
13 client.

14       And that's all in the service of, you know, kind of  
15 reaching those goals and, you know, treating that patient.  
16 Right? And so those types of processes, I guess, they're still  
17 possible. Right? You get on the phone and, you know, you've  
18 got the consent, you get on the phone and you're able to kind of  
19 have that contact, but it might be a little bit more difficult.

20       **Q.** Is there any value to ... in your experience of  
21 military veterans, say for example suffering from PTSD and major  
22 depressive disorder and anxiety disorder, is there any advantage

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1 to this idea that there may be a little more structure and  
2 routine when they're being treated at an OSI Clinic as opposed  
3 to being out in the community? And when I say "being out in the  
4 community", I mean not affiliated with an OSI Clinic.

5       **A.** I think you can argue that. Sure. That, you know, if  
6 they're accessing groups ... you know, we also offer groups.  
7 Right? So there's that kind of like that continuity of care,  
8 that structure, as you mentioned, you know, and then they're  
9 used to kind of coming to this facility. You know, for some ...  
10 you know, I can't speak for all of them. You know, for some it  
11 may have been a bit of a disadvantage kind of coming into the  
12 clinic and seeing other veterans. That, for some folks, can be  
13 a bit of a trigger. But I've also heard that for some folks,  
14 you know, seeing so-an-so, you know ... you know, I haven't seen  
15 that person for awhile. Right? So ... and maybe also seeing,  
16 Oh, so if they're also kind of going through difficulties,  
17 right? So that kind of ... you know, maybe that sense of  
18 connection, right, but not for all clients.

19       **Q.** And as a treating clinical psychologist of military  
20 veterans, have you had experiences where you're treating a  
21 military veteran and then go down the hall or you make a phone  
22 call within the clinic to, say, the treating psychiatrist or you

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1 speak to the nurse practitioner, and if that sharing of  
2 information between the group was to your advantage and  
3 ultimately to the client's advantage in administrating the  
4 treatment ... administering the treatment?

5 **(10:40)**

6 **A.** Yes, numerous times. Absolutely. Right? Again, the  
7 kind of easy access, right, and in terms of ... you know, I'm  
8 sure we're going to get into it there but, you know, just kind  
9 of the, you know, collaboratively working on, you know,  
10 recommending, you know, the inpatient ... the residential  
11 treatment program, right, in Montreal. And so, you know, having  
12 Dr. Njoku there and the nurses, right, kind of help out. Yeah.

13 **Q.** So we're going to get into your experience with Lionel  
14 Desmond. So how long did you act as Lionel Desmond's clinical  
15 psychologist?

16 **A.** So in preparation for this, I kind of looked at the  
17 dates there. I think my first contact would have been June  
18 24th, 2015 and the last contact, over the phone, would have been  
19 October 18th, 2016. So I think roughly, you know 16 months.  
20 That's an approximate. Yeah.

21 **Q.** And so just to get those dates correct again, so your  
22 first contact with him would have been June 24th, 2015?

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1           **A.**    '15. And it's possible ... sorry. There's ... it's  
2 possible that I would have had contact with him over the phone.  
3 That would have been the first session, I believe, June 24th.  
4 But roughly June 2015 to October of 2016.

5           **Q.**    Okay. And do you recall ... if you look at page eight  
6 of the Exhibit 244 ... Do you see that there, Doctor?

7           **A.**    Yes.

8           **Q.**    Page eight. So this looks like ... it says, "Date of  
9 triage - May 7, 2015. Triage conducted by Christine  
10 Lillington."

11          **A.**    Uh-huh.

12          **Q.**    Is this sort of a standardized document for when a  
13 referral comes in and a client is assessed sort of for the first  
14 time?

15          **A.**    Yeah. That's the telephone triage.

16          **Q.**    And do you recall this as May 7, 2015, the sort of  
17 first date that the OSI Clinic in New Brunswick would have had  
18 contact with Lionel Desmond?

19          **A.**    Yes, I believe.

20          **Q.**    And to the left it says, "Date of Referral, April 16,  
21 2015." So is it your understanding that the referral to the OSI  
22 Clinic in New Brunswick as it relates to Lionel Desmond took

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1 place on that date?

2 **A.** Yes.

3 **Q.** And then it says, "Date Received". So I guess  
4 referral made up April 16, 2015 and it's received May 1st, 2015?

5 **A.** Mm-hmm.

6 **Q.** And do you recall who made the referral?

7 **A.** I believe it came directly from the base, Dr. Joshi.

8 **Q.** Okay. And when you say "the base", are you referring  
9 to Canadian Armed Forces?

10 **A.** Yeah. Base Gagetown, I suppose, yeah.

11 **Q.** Okay. So if we look at page 13, Doctor, this is a  
12 series of pages, I guess, 13 through 16. Do you recognize what  
13 this is? It says "Referral Form". Do you recognize what this  
14 is?

15 **A.** Yes.

16 **Q.** What is it?

17 **A.** So this is a referral form that was ... that ... from  
18 Dr. Joshi.

19 **Q.** So he was the person that sent the referral to OSI New  
20 Brunswick.

21 **A.** Uh-huh.

22 **Q.** And do you recall what the referral was for?

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1           **A.**    She has a ... he had a diagnosis for PTSD and major  
2 depressive disorder, my recollection there and reviewing the  
3 notes there and so it was to get ongoing services for his OSIs.

4           **Q.**    And I understand ... so the referral comes in. So  
5 step one would have been to do some sort of a triage. Is that  
6 correct?

7           **A.**    Uh-huh.

8           **Q.**    And that triage, you understand, would have been  
9 conducted on May 7th by Christine Lillington?

10          **A.**    Yes.

11          **Q.**    And we're going to go back to the details of that  
12 initial triage, but I want to get a sort of concept of how  
13 frequent your involvement was with Lionel Desmond. So we know  
14 the start date with you of June and the completion ... the last  
15 time you would have had contact in October. So we have an  
16 opening date of May 7, 2015 of a file at the OSI Clinic in New  
17 Brunswick. Is that correct?

18          **A.**    Yes.

19          **Q.**    And when was the file closed? If we look to page ...  
20 I believe it's three.

21          **A.**    I believe it's December 22nd.

22          **Q.**    Of 2016?

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1           **A.**    2016, yes.

2           **Q.**    Who make the ultimate determination to close the file  
3 as it relates to Lionel Desmond on December 22nd, 2016?

4           **A.**    I remember, you know, having a discussion with Dr.  
5 Njoku on that day, the psychiatrist ... treating psychiatrist  
6 and he was comfortable with me closing the file. As I mentioned  
7 a little bit earlier, right, if I'm working with someone and I'm  
8 ending services with that individual, it may not mean that the  
9 psychiatrist will be, you know, kind of ending treatment.  
10 Right? So I wanted to ensure ... make sure that he was okay  
11 with my closing the file.

12           In Mr. Desmond's case, we had ... you know, he was ... you  
13 know, he had moved to Nova Scotia and, you know, we had, you  
14 know, attempted to connect him with OSI ... Halifax OSI, Nova  
15 Scotia. So those were some of the details that kind of went  
16 into us closing the file on our end.

17           **Q.**    And we're going to get into all the circumstances  
18 surrounding ...

19           **A.**    Sure.

20           **Q.**    ... the file being closed and why and where Lionel  
21 Desmond was at the time.

22           **THE COURT:**    Mr. Russell? Sorry to ...

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1           **MR. RUSSELL:**    Yes.

2           **THE COURT:**     ... interrupt. I'm just going to ask you a  
3 question. So with regard to the letter that's page three of  
4 Exhibit 244, is it ... I take it it's your intention to return  
5 to that letter at some point in time and to break down the  
6 various sentences and the information that's contained in there  
7 to kind of establish where it came from with Dr. Murgatroyd?

8           **MR. RUSSELL:**    For sure. Yes, Your Honour. I'm just  
9 simply trying to establish a baseline of file opened, when he  
10 would have first had contact, last contact, and file closing.

11          **THE COURT:**     All right. So that was the letter that, for  
12 the record, was letter written December 22nd, 2016. It was  
13 addressed to Ms. Doucette. And, Dr. Murgatroyd, do you know ...  
14 recall who Ms. Doucette was at the time you wrote that letter?

15          **A.**    Yes, Your Honour. It was Lionel Desmond's case  
16 manager with Veteran Affairs.

17          **THE COURT:**     At Veterans Affairs? And ...

18          **A.**    Uh-huh.

19          **THE COURT:**     ... it seemed to suggest that you had a  
20 discussion with Ms. Doucette and that letter is, in part, a  
21 confirmation of the conversation and the information you had  
22 received from her following that conversation. Do I read that

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1 correctly?

2       **A.** Yes. We'd had at least one conversation about the  
3 plan of closing the file once his case was referred out.

4       **THE COURT:** Right. Thank you.

5       **A.** And this is ... oh, sorry. This is a pretty standard  
6 ... you know, when we are closing a file, you know, we would  
7 typically let the referral source know that we're closing the  
8 file.

9       **THE COURT:** Of course. All right. Thank you. Sorry,  
10 Mr. Russell.

11       **MR. RUSSELL:** Oh, no. That's fine.

12       **THE COURT:** I'll let you proceed and return to that as  
13 you had planned. Thank you.

14       **MR. RUSSELL:** Thank you, Your Honour.

15       So now that we've sort of established a general timeline of  
16 referral, first contact, when the file was ultimately closed.  
17 Are you able to estimate how many contacts you might have had  
18 with Lionel Desmond over the course of those 14 months?

19       **A.** Yeah. And, you know, just out of interest, I ... in  
20 reviewing the file, you know, I looked at how many sessions we  
21 would have ... what I consider face-to-face sessions, I think  
22 were approximately nine and 20 phone contacts, three of those

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1 that were considered phone sessions. And so ... and I believe  
2 about eight no-shows and two cancellations. So that's roughly,  
3 you know, what I ...

4 **(10:50)**

5 **Q.** And we're going to go over each particular session.  
6 So would you say that ...

7 **A.** Sure.

8 **Q.** ... you were trying to meet with him fairly  
9 frequently?

10 **A.** Yes. You know, when treating, you know, individuals  
11 with an OSI, typically we're meeting on either a weekly or  
12 biweekly basis, depending on where we're at in treatment.  
13 Right? So it's intensive ... it's an intensive form of therapy.

14 **Q.** And why did ... in Lionel Desmond's case, why was the  
15 approach an intensive form of therapy and meeting ... the  
16 importance of meeting so frequently with him? Why was that?

17 **A.** The importance of meeting so frequently?

18 **Q.** Yes.

19 **A.** Yeah. You know, so given the ... you know, the mental  
20 health challenges, right, of the PTSD and the major depressive  
21 disorder, right, and so I approached it, you know, similar to  
22 how I would have approached it with other individuals that were

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1 kind of experiencing that. And on top of that, you know, he was  
2 experiencing stressors and, you know, kind of having difficulty  
3 with that transition. You know, he was also ... the alcohol use  
4 disorder early on that Dr. Njoku had identified. So the idea  
5 was to meet on at least a biweekly basis but, you know, on a  
6 weekly basis if possible.

7 Q. And it was your opinion that he needed that frequent  
8 contact.

9 A. Yes.

10 Q. And would you say that he would have needed that  
11 frequency to maintain stability, I guess, in the community?

12 A. Yes. And also working on that therapeutic alliance,  
13 as we talked about earlier.

14 Q. So when he first came to the clinic and he's ... he  
15 comes to your attention, what was the diagnosis? You said PTSD  
16 and major depressive disorder, is that correct?

17 A. Yes.

18 Q. And there was some indication that he might have had,  
19 I believe it was comorbid alcohol abuse? Am I saying that  
20 correctly?

21 A. Yeah. And I would have to review the file, but I ...  
22 I'm not sure if that came with the referral, but I certainly

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1 know that Dr. Njoku would have identified that.

2 Q. Okay. So prior to your first session with him, I'm  
3 curious to know what information you had. So before Lionel  
4 Desmond walks in the door, you have a referral. What do you  
5 know about him? What sort of charts or access information do  
6 you have ... or did you have?

7 A. So I have access to what we have here from Dr. Joshi  
8 and that was sent from Base Gagetown. I have, of course, you  
9 know, the intake from Christine Lillington and I believe that's  
10 it.

11 Q. So in terms of documentation that you have, from  
12 Canadian Armed Forces you would have had ... if you look at page  
13 100 of the Exhibit 244 ...

14 A. Uh-huh.

15 Q. So essentially from page 100 to 157, we have a series  
16 of National Defence documents. They appear to be as it relates  
17 to reports of Dr. Joshi, who was the psychiatrist that made the  
18 referral. Do you recall when you received those documents?

19 A. I don't recall. Usually, that is ... from my  
20 recollection, is already part of the file once ... you know,  
21 once ... at the point where I'm working ... you know, starting  
22 working with an individual, I believe that ... and I think we

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1 see the date here, right, printed on ... oh, maybe that's from  
2 their end. But my recollection is that usually the ... this  
3 will already be part of the chart.

4 Q. And we see a date in the top right-hand corner. It  
5 says, "Attention. No doctor. Family, Mike Hughson." But it's  
6 dated June 24, 2015. Does that seem to be ...

7 A. Right.

8 Q. ... around the time you would have had access to his  
9 Canadian Armed Forces medical documents?

10 A. Yes.

11 Q. And you said in terms of the documents, you were  
12 familiar with ... were you familiar with the progress notes and  
13 reports of Dr. Joshi?

14 A. Yes, I certainly would have looked at this. Yeah.

15 Q. And it would have outlined his progress and his  
16 sessions while being treated at the Canadian Armed Forces level?

17 A. Uh-huh.

18 Q. Would this have been helpful in formulating your  
19 treatment plan as it relates to Lionel Desmond?

20 A. Yeah. Absolutely. You look at the referral, the  
21 referral source and the assessments, the summary reports, and  
22 the followup. It kind of gives you a sense as to, you know, how

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1 the client is functioning, how he's doing, you know, before we  
2 received the client. Yeah.

3 Q. Does it give you a sense of sort of maybe what  
4 treatments seem to work best, what don't work?

5 A. You know, with a psychiatric ... you know, report from  
6 a psychiatrist, you know, we'll get a lot of information on  
7 medication, certainly. So there is that information. Sometimes  
8 there will be information on therapeutic approaches, but not  
9 always.

10 Q. And did you find the information from Dr. Joshi of  
11 assistance to you when you were meeting with Lionel Desmond and  
12 coming up with a treatment plan for him?

13 A. Yes.

14 Q. And why was that?

15 A. Well, again, you get a sense of, you know, what were  
16 his experiences, what's the background. Right? What's the  
17 history? So you get all of this information. It kind of gives  
18 you ... paints a picture, right, as to what you're receiving.  
19 Certainly, we're looking at some of the ... some of this ... you  
20 know, our own intake but it's nice to have that for preparation.  
21 And, also, as we kind of mentioned, the final few sessions, how  
22 he's doing, right, more recently.

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1           **Q.**    In the final sessions with Canadian Armed Forces, you  
2 mean, before he gets referred out?

3           **A.**    Yes.

4           **Q.**    Okay.

5           **A.**    Yes.

6           **Q.**    And sort of ... why is it important to sort of know  
7 where the client left off at the referral agency when they come  
8 to you? Why is that valuable?

9           **A.**    Yeah. You get a sense of ... you know, especially, as  
10 we kind of talked about, just this medical release, this  
11 transition out of the Forces. How is a client, you know, coping  
12 with all of that? Right? And, you know, in terms of when we  
13 see this individual, right, it kind of helps us prepare for  
14 that. Right? Or if they're kind of struggling with it or if  
15 they're not. Right? So that's valuable information.

16          **Q.**    How important is it to you as the clinical  
17 psychologist and one of the main players, I guess, in Lionel  
18 Desmond's continuity of care, that you get adequate and detailed  
19 information from the referral agency?

20          **A.**    Yeah. You know, when it comes to continuity of care,  
21 it's ... it is really important. Right? You know? Because  
22 this is the work that's been done with this individual. You

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1 know? You kind of get a sense as to, you know, what has been  
2 done, how, you know, has ... you know, in terms of how well it  
3 was received, right, in terms of the impact, you know, the ...  
4 you know, what's worked, what hasn't worked. And, you know, if  
5 he's done certain things well, and that's worked well, you know,  
6 we'll see if we can kind of carry that on, you know, in terms of  
7 coping strategies, in terms of techniques. And if there are  
8 things that really haven't worked, well, you know, we might not  
9 look at those things. Right?

10 **(11:00)**

11 And you kind of get, also, a sense as to, you know, what's  
12 going on in this individual's life, right, when it comes to, you  
13 know, what's important; you know, in terms of people that are  
14 around this person. And so you get a lot of information. And,  
15 of course, you know, that information is there. You're going to  
16 be doing your own intake and kind of come up with your own  
17 interpretation on things, but it's really valuable having that  
18 with, you know, individuals that have a lot of experience,  
19 right, working with that type of clientele.

20 **Q.** Okay. I'm going to leave it there for now, the  
21 Canadian Armed Forces disclosure. In terms of the referral,  
22 when you are ... when you now have Lionel Desmond under your

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1 care, did you receive any records from the provinces, in  
2 general? And what I mean is New Brunswick or Nova Scotia as it  
3 relates to hospital records, about hospital visits, emergency  
4 room visits, family physician records, private clinician  
5 records, or clinics that he might have attended? Did you get  
6 any of that information when you were treating him?

7 **A.** Not that I can remember. And when we receive those  
8 types of documents, they would be added to the file.

9 **Q.** So when you're treating Lionel Desmond at an OSI  
10 clinic for occupational stress injuries, you recognize that it's  
11 important that he meet with great frequency, would it have been  
12 helpful to know if he was hopping around the province in various  
13 ERs perhaps, in a form of crisis? Would it have been helpful to  
14 know the background and details of those visits?

15 **A.** Yes.

16 **Q.** And if he had have maybe reached out to a clinic in  
17 Guysborough and met with a general practitioner in a form of  
18 mental health crisis, would it have been helpful to know the  
19 context of that information?

20 **A.** Yes, it would have been important. Yeah.

21 **Q.** And why is that?

22 **A.** Well, you know, you're working with that client,

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1 right, and, you know, the more information the better in terms  
2 of what's going on in that individual's life. Right? And, you  
3 know ... and getting that information is ... can be quite vital,  
4 right, in terms of the ... we're talking about the  
5 conceptualization of the case and in terms of the treatment  
6 plan. Right? Well, there ... you know, we might have to kind  
7 of, you know, change that treatment plan based on what's going  
8 on with the individual, right, and in terms of recommendations  
9 and in terms of, you know, how we approach the case. Yes.

10 Q. And in your experience in dealing with clients ...  
11 veterans, do you often get information from the provinces as to  
12 family charts, clinic charts, ER visits? Is that information  
13 shared with your OSI Clinic?

14 A. In ... not always. You know, sometimes we will get it  
15 if the individual has consented. We have, in the province ...  
16 and I don't know if this has been discussed yet there, but we  
17 have various systems, you know, that exist when it comes to  
18 documentation. And even within, you know, Horizon, for example  
19 ... and it's not necessarily ... I'm not necessarily able to  
20 access that information. As you can see, we have a paper file  
21 here. We didn't operate electronically ...

22 Q. And I ...

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1           **A.**   ... unlike some of the other ...

2           **Q.**   And I can appreciate that you maybe can't comment on  
3 the other end of the ER doctor or the clinic doctor that sees  
4 him in Nova Scotia on a particular date. Would they have any  
5 way ... would that doctor have any way of knowing, if it wasn't  
6 for the client telling him, Oh, by the way, I'm seeing Dr.  
7 Murgatroyd for my OSI in New Brunswick, is there any system that  
8 lets practitioners know that Lionel Desmond is affiliated with  
9 the OSI Clinic in New Brunswick?

10          **A.**   Not to my knowledge. I ... it's possible. That might  
11 be a better question for like management, admin support, right,  
12 where, you know ... because, of course, we're still Horizon.  
13 We're still, you know, a public service. Right? So it is  
14 possible but I'm not sure on that, actually.

15          **Q.**   But you can't comment, and I believe you did, that  
16 that information is always helpful when it's available.

17          **A.**   Yes.

18          **Q.**   And, finally, we're going to get into the Ste. Anne's  
19 Clinic in Quebec, the referral. Did you receive any  
20 documentation from them after Lionel Desmond leaves the Ste.  
21 Anne's Clinic?

22          **A.**   Yes. And it's the document that is on the chart.

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1           **Q.**    So if we look ...

2           **A.**    The report.

3           **Q.**    If we look to page 85 ... and we're going to get into  
4 the details, but I just want to establish a baseline ... I guess  
5 84. Do you see that, Doctor?

6           **A.**    Yes.

7           **Q.**    So that goes between 84 and page 93. So if my math is  
8 right, that is approximately nine pages. So those nine pages,  
9 is that the extent of the information that you received from  
10 Quebec?

11          **A.**    Yes.

12          **Q.**    And there's a fax ... looks like a fax heading on page  
13 84 that says, "October 7, 2016". Is that your understanding of  
14 when that information would have been received in New Brunswick?

15          **A.**    Yes.

16          **Q.**    And again just to establish a baseline, do you recall  
17 when it was that Lionel Desmond attended the Ste. Anne's  
18 program?

19          **A.**    I think the dates are here between ... I don't want to  
20 get it wrong. Between ... if we're also counting the ...  
21 because there are two programs ... you know, two phases, if you  
22 will, from May 30th to August 15th is what I'm seeing here.

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1           **THE COURT:**       Those are the dates ... there's dates on  
2 page 85 which shows ...

3           **A.**     Yes.

4           **THE COURT:**       ... the main dates. And you might just want  
5 to put them into the record, Mr. Russell.

6           **MR. RUSSELL:**     And that was page 85, Your Honour?

7           **THE COURT:**       Page 85.

8           **MR. RUSSELL:**     So it appears, Doctor, if we look at page  
9 85, that he would have been admitted to the Ste. Anne's program  
10 on May 30th of 2016 and ultimately discharged, it says, from the  
11 program, August 15th of 2016. Is that your recollection?

12          **A.**     Yes.

13          **Q.**     And we're going to get into your knowledge of what had  
14 occurred on ... Quebec, but I'm mostly interested in information  
15 that you received from Quebec. So, in totality, those 11 or so  
16 pages, is that all the information you received from Quebec as  
17 it relates to Lionel Desmond?

18          **A.**     Yes.

19          **Q.**     And your understanding is that information was  
20 provided several months later. If he's discharged August 15th,  
21 you don't receive that information until October 7, 2016?

22          **A.**     Yes.

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1           **Q.**    So, Doctor, we're going to go back to Lionel Desmond  
2 and the first information that you have as it relates to him in  
3 terms of the initial intake.  So if you look to page 81 of the  
4 Exhibit 244, this, Doctor, appears to be a typed summary at the  
5 clinic from triage nurse Christine Lillington, dated May 7,  
6 2015, was ... which you indicated was the date of the telephone  
7 triage.  Were you familiar with that document?

8           **A.**    Yes.

9           **Q.**    And I'm going to ask you a series of questions about  
10 your understanding of Lionel Desmond after that initial intake.  
11 So what was the purpose for Lionel Desmond's referral?

12    **(11:10)**

13           **A.**    As I mentioned earlier, right, it's the continuity of  
14 care for ongoing mental health challenges, diagnosis of PTSD and  
15 MDD and, you know, the ... also just releasing from military  
16 services.  Right?

17           **Q.**    And so on the date of this intake, if we look at page  
18 nine ... and, to your knowledge, did it appear as though Lionel  
19 Desmond quite understood why he was accessing the services of  
20 the OSI Clinic?  At the top of page nine, it says, "Client's  
21 understanding reasons for referral."

22           **A.**    Yeah.  It says, "Unsure".  You know, this would have

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1 ... document would have been completed by Christine Lillington,  
2 not myself.

3 Q. In your meeting with him for the first time, did he  
4 appear to really understand why he was at the OSI Clinic in New  
5 Brunswick and what, in particular, he needed?

6 A. My recollection is not clear on that, you know, other  
7 than, you know, what's in the note. Certainly, I would have had  
8 an opportunity to kind of review, you know, the clinic  
9 procedures, you know, confidentiality limits, things of that  
10 nature. So I had that opportunity to kind of tell him a little  
11 bit more about the services that we offer.

12 Q. And, initially, did he appear to have any sort of  
13 insight as to what his conditions were, PTSD, major depressive  
14 disorder, what he had to do to maintain his stability? Did he  
15 appear to understand that and have a good hold on that or ...

16 A. You know, I'd say that ... I mean I'd say, like,  
17 partial insight. I think I would agree with some of the other  
18 doctors in ... you know, obviously, my recollection other than  
19 what's based on in the note, is ... I'm kind of basing my  
20 testimony on my notes mostly. Right?

21 Q. Yes. So you understood what medications he had been  
22 prescribed.

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1           **A.**    Yes.

2           **Q.**    And when we look at page eight, what medications had  
3 he been prescribed and had been taking at the time of the  
4 referral, to your knowledge?

5           **A.**    Right.  So there was Effexor, risperidone and  
6 zopiclone and Ativan.  And he was also prescribed medicinal  
7 marijuana, one gram a day.

8           **Q.**    Do you generally know what those medications were for?

9           **A.**    And Viagra.  Yeah.  Generally, yes.  You know, I'm not  
10 a physician or a psychiatrist, but yes.

11          **Q.**    And what were they for, generally, Doctor?

12          **A.**    Well, you would have, you know, Effexor, which I  
13 believe is an antidepressant, would be for depression.  the  
14 risperidone, antipsychotic, I believe was for the ... you know,  
15 sometimes prescribed for the agitation.  And zopiclone would be  
16 for the sleep, and Ativan would be for anxiety and distress.  
17 And the Viagra would be for sexual difficulties.  Medical  
18 marijuana would be for the distress, as well, I imagine,  
19 anxiety.

20          **Q.**    When you first have contact with him, and at the  
21 initial stages, did it appear to you as though he was motivated  
22 to engage in treatment?

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1           **A.**    There was certainly a guardedness and a distance. We  
2 see that a lot. We see that regularly, I should say, you know,  
3 even in the community setting. Right? There's just that  
4 sometimes difficulty opening up and being guarded and kind of  
5 being uncomfortable with the situation with a new clinician, a  
6 new health professional. So sometimes we see that, but  
7 certainly I did observe that, a general guardedness.

8           **Q.**    Were you ever able to drill down what was the sort of  
9 cause or underlying factors into that guardedness that he posed  
10 early on?

11          **A.**    Yeah. We talk about, you know, there can be different  
12 variables at play. Right? Is it the PTSD? You know, is it the  
13 PTSD, not wanting to share certain information or is it, you  
14 know, just not being interested in the process? Right? So it  
15 is kind of difficult to tease apart. And I don't think at that  
16 time that it was clear.

17          **Q.**    If we look at page nine of that initial referral ...  
18 and I'm mindful that you didn't do that initial intake  
19 assessment. At page nine, it indicates, "Possession of  
20 firearms, yes, locked cabinet." So was it your understanding  
21 that he was in possession of firearms at the time of the  
22 referral?

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1           **A.**    Yeah.  Based on this, yes.

2           **Q.**    As well, it indicates, at the bottom, "Client denies  
3 current suicidal id- ... SI/HI (which we know is suicidal  
4 ideation/homicidal ideation)."  Do you know ... when they're  
5 assessing that at the initial intake stage, how is that  
6 assessed?  Do you know?

7           **A.**    I wouldn't be able to say for sure.  I ... you know,  
8 as we kind of talked about earlier with the suicide assessment,  
9 right ... suicide risk assessment, my assumption is that they  
10 would do something similar to that.  And sometimes it's also  
11 just kind of based on, you know, what we have in front of us,  
12 right, the presentation.  Right?  If the individual is really,  
13 you know, distressed, right, then we may have to do a little bit  
14 more digging, if you will, right, in terms of checking that out.  
15 You know, it's our responsibility.  But I wouldn't be able to  
16 say for sure.

17          **Q.**    And at the bottom, it states, "Stated has been  
18 increasing his drinking daily times three beers.  Could be  
19 problematic.  Using it as mood is low."  So was it your  
20 understanding that he had been consuming alcohol at the time he  
21 became involved with you at the OSI Clinic?

22          **A.**    Yes.

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1           **Q.**   And did it appear as though that would certainly be  
2   problematic for him and his underlying conditions of post-  
3   traumatic stress disorder/major depressive disorder?

4           **A.**   Yes.

5           **Q.**   Was there any indication that he had been using  
6   alcohol as a way of sort of coping with the stress and anxiety  
7   that he was under as a result of those diagnoses?

8           **A.**   Yes.  And possibly the ... you know, just kind of like  
9   the stressors in the transition, right, the adjustment.

10          **Q.**   And speaking to the transition, when we look at page  
11   ten of that initial intake, it's noted by Ms. Lillington ... and  
12   I'll read it under "Additional Notes.  Client expressed he is  
13   not doing well with mental health.  Stressed about upcoming  
14   medical release."  What did you understand the "upcoming medical  
15   release" ... from what?  What was he being released from?

16          **A.**   Yeah.  From the Canadian Forces.

17          **Q.**   Did he ever discuss with you, at those early stages,  
18   his stress that he felt as it relates to being released from the  
19   Canadian Armed Forces?

20          **A.**   Yeah, he did.  I think there's an instance ... an  
21   entry where he had mentioned something to the effect of, you  
22   know, wishing that he was still in the military ...

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1 Q. Is this something that appears ...

2 A. And that he was ...

3 Q. Go ahead. Sorry.

4 A. Yeah. That he'd be able to, yeah, stay in the  
5 military basically.

6 Q. Did this seem to be something of significant anxiety  
7 and stress for him, this upcoming release from the military?

8 A. Yes.

9 Q. And would you say that he was coping well with that?

10 A. No.

11 Q. And in what way? Why wasn't he coping well with being  
12 released from the military?

13 **(11:20)**

14 A. Well, as ... and, you know, I don't have ... my  
15 recollection is not clear on exactly why. You know, I can  
16 speculate and just kind of go generally, you know, that ... you  
17 know, a lot of folks, they get a sense of meaning and purpose,  
18 right, and that's what they've known for "x" amount of years.  
19 And so moving away from that and the unknown of what's next,  
20 right, can be very stressful.

21 Q. It's also indicated, at page ten in that initial  
22 intake under "Additional Notes" it says, "Stressed ..." And it

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1 says ... okay. Sorry. "Wife in Nova Scotia. Client to put  
2 house up for sale here in New Brunswick and possibly move to  
3 Halifax." Did you get any sense of if that was a stressor for  
4 Lionel Desmond, this idea of the sale of his house in New  
5 Brunswick?

6 **A.** Yeah. No, that was an added stressor. Absolutely.

7 **Q.** And did you get any sort of understanding of when he  
8 comes to see you and he gets involved in the clinic in May of  
9 2015 ... how is his housing situation? Was he sort of decided  
10 as to where he was going to live or did it appear to be in flux?

11 **A.** Specifically where he was going ... I believe it was  
12 in the Antigonish area, to my recollection. It's not clear, you  
13 know, specifically where he was going to move with whom. Yeah.

14 **Q.** So this concept of transitioning from military life to  
15 civilian life, is this something you often see when you're  
16 treating military veterans?

17 **A.** Yes. Yes, absolutely.

18 **Q.** How common or how prominent is that, I guess, stressor  
19 for a military veteran, this concept of leaving a military to a  
20 civilian life?

21 **A.** Yeah. It's ... in my experience, I can speak for my,  
22 you know, experience, it's something that we see frequently.

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1 They are used to this culture. They are used to this way of  
2 operating, the structure, the routine; you know, the order, if  
3 you will. And kind of moving from that, something that they've  
4 known for "x" amount of years, and then going to civilian life,  
5 right, it's a bit of a shock for some, shock to the system.  
6 And, you know, some individuals struggle with that.

7 Q. And did Lionel Desmond seem to have that "shock to the  
8 system" and share in that struggle?

9 A. I would say yes.

10 Q. Do you know what sort of ... from a clinical  
11 perspective and in this concept of continuity of care, what can  
12 assist in easing that stress and tension? Because I understand  
13 that it would probably impact his underlying conditions of post-  
14 traumatic stress disorder. It's a circular ...

15 A. Sure.

16 Q. ... sort of thing. What sort of things can assist in  
17 alleviating that?

18 A. Well, it's ongoing treatment certainly. And, you  
19 know, there are other programs. Veteran Affairs would probably  
20 be, you know, best to kind of talk about these programs, you  
21 know. And I know, certainly, as they're releasing from the  
22 military that there certainly are programs and they prepare, you

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1 know, individuals for the transition. So I can't speak to that  
2 too, too much because of ... it's ... you know, it's not  
3 something that I did personally.

4 We have ... and maybe we'll get to it a little bit later.  
5 You know, there are support networks. The OSI support ...  
6 social support network, that is a nice resource. Wounded  
7 Warriors, you know, they ... to kind of keep that camaraderie,  
8 to keep that connection. So there's the ongoing care. There  
9 is, Can we connect that individual to, you know, other veterans.  
10 Right?

11 And certainly, look, it wasn't Lionel ... in Lionel's case,  
12 to my knowledge, you know, he wasn't headed in this area. But  
13 for some folks, it's kind of retraining. Right? It's ... you  
14 know, this chapter is over but, you know, can we get you to, you  
15 know, something else? Right? So in terms of, you know, kind of  
16 motivation, right, you know, kind of getting them moving in that  
17 direction.

18 Q. So I'm going to take you to page 81, which is that  
19 typed intake triage report from Nurse Lillington. And in the  
20 middle of that report, it states: "His wife has remained in  
21 school in Nova Scotia for the past six years and he stated they  
22 tend to argue a lot, causing the long-distance relationship to

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1 be strained."

2 Was that your understanding of the initial status of the  
3 relationship when he became involved with the OSI Clinic in New  
4 Brunswick? It was a strained relationship with his wife?

5 **A.** Yes.

6 **Q.** This idea of a strained relationship, did it appear  
7 sort of prevalent and consistent throughout the 14 months you  
8 had spent with Lionel Desmond?

9 **A.** Yes, I'd agree to that.

10 **Q.** Would you say that it was quite prominent? It was a  
11 recurring stressor in his life?

12 **A.** I'd say recurring. You know, there were moments, you  
13 know, where they seemed to be doing better. But for the most  
14 part, yes, strained.

15 **Q.** And up until sort of ... you know, between the initial  
16 triage and the first time you met with him and the ultimate file  
17 closure on December 22nd, did the status of his relationship  
18 ultimately ever seem to improve or get better or get on track?

19 **A.** It was kind of ups and downs. I wouldn't say that  
20 there was an improvement. And after his release from Ste.  
21 Anne's, with the few contacts that I had then, things seemed to  
22 be better in general. But I can't go beyond, you know, what's

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1 noted, so I don't know for sure. Right? I think things were  
2 going generally better for him. But if there's nothing noted  
3 with respect to the relationship, I wouldn't want to speculate.

4 Q. Okay. So before we get into the individual sessions,  
5 which really get down to the crux of your contact with Lionel  
6 Desmond, your observations, I just want to talk to you a little  
7 bit about the consent release of information. If we look at  
8 page 17 of the New Brunswick records, we're looking at some form  
9 of consent that appears to be signed by Lionel Desmond. What  
10 consent is this?

11 A. I think it's the consent to him ...

12 Q. You can look at ...

13 A. ... agreeing to send the file ... oh, that one.

14 Q. We can look at page 18.

15 A. Are you ...

16 Q. That might make it simpler for you, the next page.

17 A. Oh, 18. Sorry. I was on ... oh, that one? Yeah.

18 Q. Yes.

19 A. So that ... yeah. That one ... CROMIS is a Client-  
20 Reported Outcome Monitoring System, it's a mouthful, where  
21 individuals when they come into the ... for their appointments,  
22 they will go over a checklist of symptoms to give us a sense as

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1 to, you know, how they're doing with respect to depression, with  
2 respect to anxiety, with respect to PTSD. And so he chose to  
3 participate.

4 Q. And he consented on June 24th to that information?

5 A. Yes.

6 Q. If we turn back to page 17; in particular, this  
7 consent it's titled, "Release of Information". And what appears  
8 to be scratched out but ... "I hereby authorize the Fredericton  
9 OSI Clinic to release information, exchange information, collect  
10 information from (and it says) Shanna Desmond", who we know is  
11 his wife. Did he initially allow you consent to allowing you to  
12 share information and contact her?

13 **(11:30)**

14 A. Yes.

15 Q. And what's the purpose, from a clinical perspective,  
16 what's the value in the exchange and release of information to  
17 his spouse and to collect information from his spouse?

18 A. Well, you're able to get collateral information from  
19 individuals that are closest to the client and so that can be  
20 valuable information. You know, oftentimes, you know, when  
21 we're assessing a client, we'll have a partner come in and kind  
22 of get that collateral information. For therapeutic processes,

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1 it can also be valuable to kind of get their perspective.

2 Q. And I understand, if we look back at that document,  
3 there seems to be handwriting in the right corner. It's "MM".  
4 So I'm assuming that's your handwriting? Mathieu Murgatroyd?

5 A. Yes.

6 Q. And it says, "Client rescinded consent April 25th,  
7 2016." Is that correct?

8 A. Yes.

9 Q. So I understand from that, at some point did Lionel  
10 Desmond revoke that consent to exchange information and share  
11 with his wife, Shanna Desmond?

12 A. Yes.

13 Q. Do you recall how that came about, why he went from  
14 initially wanting to share the information and gather  
15 information from her to rescinding that and requesting that that  
16 no longer be the case?

17 A. Yeah, and I, you know, I know that there was a ...  
18 some sort of a fight or, you know, conflict in the relationship.  
19 I think that we ... there is a note on that that we could  
20 explore.

21 Q. Okay. And we will as we go through the individual  
22 sessions, but just for now, so he did rescind his initial

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1 consent.

2 **A.** Yes.

3 **Q.** The other consent I'm interested in, page 22, what is  
4 this particular consent? What does this relate to? If you look  
5 to the middle of the page.

6 **A.** Mm-hmm. So it's him consenting to us being able to  
7 communicate with VAC.

8 **Q.** And what's the purpose of, the importance of, I guess,  
9 the OSI clinic in New Brunswick communicating information, as it  
10 relates to Lionel Desmond, with Veterans Affairs Canada?

11 **A.** Well, it's really a team effort, right? And you've  
12 got a case manager that is often involved and the case manager  
13 is really kind of managing the case, right? Is involved in the  
14 client's care, referrals, things of that nature. And so we  
15 regularly communicate with VAC case managers.

16 **Q.** And finally, the third consent I want to ask you about  
17 is on page 23. It says "Consent for Collection of Information".  
18 Did you see that?

19 **A.** Yes.

20 **Q.** And it says, "I consent to allow OSI Fredericton, New  
21 Brunswick ..." and again, it's in relation to Shanna Desmond.  
22 Do you see that?

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1           **A.**    Yes.

2           **Q.**    What is the purpose of having this particular consent?  
3 How is it different than the others?

4           **A.**    Yeah, it looks like this one is, this one might be a  
5 little bit more for kind of collecting the information, as I  
6 alluded to earlier, right? And so there's, in bold there, it  
7 talks about, you know, it's not, this consent is not about kind  
8 of discussing the case itself and, you know, the therapy was  
9 more for receiving information and collecting information.

10          **Q.**    And why is receiving information from a veteran's  
11 spouse important to the treating clinical psychologist?

12          **A.**    Well, again, it gives you that collateral information.  
13 Somebody that is, you know, involved in the individual's life  
14 and, you know, is aware and can share their observations, their  
15 perspective, how the individual is doing.

16          **Q.**    And if we look back to page 23, it appears as though  
17 "Shanna Desmond" is scratched out, "spouse" is scratched out,  
18 her phone number is scratched out, and it says, "Client  
19 rescinded consent April 25th, 2016. MM." So is that your  
20 notation there?

21          **A.**    Yes.

22          **Q.**    So again, there was indications, I understand, so that

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1 he revoked that consent to share information or gather  
2 information from her at some point?

3 **A.** Yes, and it looks like it was the same incident, same  
4 date.

5 **Q.** And we'll get into the circumstances at some point  
6 about why that consent was revoked.

7 So during your treatment of Lionel Desmond, did you have  
8 occasions to speak to Shanna Desmond?

9 **A.** Only on one occasion and that would've been a session  
10 where she would have, she was actually present for the therapy  
11 appointment. It was a brief appointment given that he was also  
12 seeing Dr. Njoku on that session on that day.

13 **Q.** And throughout your time in treating Lionel Desmond,  
14 did you have contact with his Veterans Affairs case manager,  
15 Marie-Paule Doucette?

16 **A.** Yes.

17 **Q.** Could you estimate how frequent that sort of contact  
18 was over the period of 14 months?

19 **A.** I don't have the exact date. Veterans Affairs would  
20 be, you know, able to tell you. When she jumped on board, I  
21 think it was near the end of 2015. And so I would ... you know,  
22 probably on a monthly/every two months basis, I would say.

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1           **Q.**    Okay.  And ...

2           **A.**    Regularly.

3           **Q.**    So we're going to move to specific sessions now that  
4 we've sort of broadly went over the various general contacts  
5 with Lionel Desmond and the interested parties.  So if we could  
6 turn to pages 82 and 83.  So at page 82, June 22nd, 2015.  So is  
7 this sort of where you would've entered your notes in terms of a  
8 database within the clinic?

9           **A.**    Yes, paper file.

10          **Q.**    And so as we go from sort of session to session, date  
11 to date, as a general rule, you make your reports directly  
12 within a system at the OSI clinic in New Brunswick?

13          **A.**    Yes.

14          **Q.**    So your first scheduled appointment with Lionel  
15 Desmond appears to be June 22nd, 2015.  Did he show up for that  
16 appointment?

17          **A.**    No.

18          **Q.**    Did he offer any explanation why he missed his first  
19 appointment with you?

20          **A.**    Yeah, it seems as though he had a medical appointment  
21 on base and that it got delayed.

22          **Q.**    Is it typical, in your experience, for a military

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1 veteran who is referred to an OSI clinic to miss the very first  
2 scheduled appointment with their psychologist?

3 **A.** No, I wouldn't say that's typical.

4 **Q.** So if we look to page 80. So I understand that  
5 appointment gets rescheduled.

6 **A.** Mm-hmm.

7 **Q.** And at page 80, you have noted, "Focus therapy session  
8 number one, June 24, 2015." So this is the very first session.  
9 This is the first time you meet Lionel Desmond, is that correct?

10 **A.** Yes.

11 **Q.** You note at the beginning you say you "went over  
12 confidentiality limits". That's in the first line of the  
13 report. What confidentiality limits did you review with him?

14 **A.** So that would've been the document at the beginning of  
15 the chart but basically the ... in a nutshell, we're talking  
16 about what confidentiality is, what that means to the client,  
17 and the limits to confidentiality. You know, for example, you  
18 know, if I judge that there's a serious risk for self-harm or  
19 onto others, you know, that we would be able to keep that  
20 between us, because confidentiality is basically that, right? A  
21 promise that we make that what, you know, is said here, stays  
22 here, or within the team. So the limits, as I said. And, you

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1 know, suspected cases of child abuse or neglect to elderly  
2 individuals. Give me the name of the health professional that  
3 would've sexually abused him in the past, we'd have to report  
4 that, and in cases of a court-ordered subpoena.

5 **(11:40)**

6 I'm paraphrasing, but we have a document that we typically  
7 review, and they already have that signed, but it's typical that  
8 we review that all in the first session.

9 **Q.** And you noted, you said you conducted an intake  
10 assessment. What did the intake assessment involve?

11 **A.** So it's basically everybody maybe has their own  
12 version, you know, of what an assessment looks like, but it's  
13 assessing the client's needs and starting a collaborative case  
14 conceptualization. So based on, you know, their presentation,  
15 based on the mental health concerns, right? Based on the  
16 history, based on, you know, everything that we're kind of  
17 looking at in the intake assessment, you know, what are the  
18 primary concerns, you know, what are some of the strategies that  
19 have helped. And so we're kind of looking at those variables,  
20 if you will.

21 **Q.** So I guess, to paraphrase, I guess, so you're, as his  
22 now treating clinical psychologist, you're trying to come up

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1 with a treatment plan, I guess, that would be effective for him  
2 at this stage in his mental health crisis, I guess. Is that  
3 fair?

4 **A.** Yes, yeah, it's a good summary, yeah.

5 **Q.** And is that what you meant when you said, "Began  
6 collaborative case conceptualization"?

7 **A.** Yes, exactly.

8 **Q.** So when you're formulating this case conceptualization  
9 at the very outset, and the first meeting, what information are  
10 you drawing from to sort of come up with an effective plan for  
11 rehabilitation or treatment? What sources of information?

12 **A.** Yeah. So I'm already ...

13 **Q.** Go ahead.

14 **A.** Yeah, I'm already aware, you know, what's on file,  
15 right? So that information is, you know, relevant. And, you  
16 know, I'm certainly kind of basing it off of, you know, what the  
17 individual is reporting and so we're ... and in terms of the  
18 history, in terms of the, kind of, current symptoms, what the  
19 trajectory looks like and, you know, what the ... the stressors  
20 that the client is experiencing at this moment. So we're  
21 looking at a ... different information to kind of come up with  
22 our conceptualization of the case.

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1           **Q.**    So if you knew that Lionel Desmond had engaged in  
2 prolonged exposure therapy or cognitive behavioural therapy,  
3 would that information have been helpful to you to know what  
4 sort of treatment strategies were used with him?

5           **A.**    Yeah, it would've been important, yeah, because for  
6 some individuals, right, if they'd done that a number of years  
7 ago, you know, they might not remember exactly, you know, what  
8 it was called and, you know, what was involved.

9           **Q.**    And in this first session, there's a discussion about  
10 a vocational rehab assignment or placement. How was he working  
11 well with others in that placement? Did he disclose to you if  
12 he had any concerns there?

13          **A.**    Yeah. It had not gone well. And there's a ... he  
14 mentions there that, you know, he had felt that some of the  
15 people were being lazy there, so he expressed concerns about  
16 that. And again, this idea, you know, there's, you know, for  
17 some individuals, they kind of see that as being, you know, part  
18 of the difference between, you know, military life and the  
19 civilian world, right, in work ethic, if you will.

20          **Q.**    So I guess his sort of work life hadn't been going  
21 well at that point, is it fair to say?

22          **A.**    Yes.

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1           **Q.**   And he was having a difficult time sort of adjusting  
2 to working with others and being around others.

3           **A.**   Yes.

4           **Q.**   In terms of his alcohol consumption, he reported to  
5 you that he was going through a fairly significant amount of  
6 bottles of beer a day. How many was his consumption? Or per  
7 week, sorry.

8           **A.**   Yeah, you know, so ... yeah, we'd have to do the math  
9 there but ...

10          **Q.**   Without doing the math, I guess, what did he disclose  
11 to you about his alcohol consumption?

12          **A.**   Yeah, he said approximately three 24-packs of beer per  
13 week, so it was really concerning.

14          **Q.**   And I understand in the report, it says, "That was the  
15 most he ever drank in his life." Do you recall that being  
16 reported to you?

17          **A.**   Basing it on the note ... I don't recall, but basing  
18 it on the note, and really kind of suggests that, yeah, he's  
19 either self-medicating or, you know, trying to cope.

20          **Q.**   So you have a military veteran that's come, being  
21 referred to you for post-traumatic stress disorder, depression,  
22 and what was initially referred to as "in remission". And then

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1 he reports to you that he's consuming approximately three 24-  
2 packs of beer per week, the most he's ever drank in his life.  
3 Is that sort of a warning sign to you? Is that a concern to you  
4 as his clinical psychologist?

5 **A.** It's certainly a red flag, it's a concern. I'm seeing  
6 a little bit later in the note that he slowed down and he's, you  
7 know, he's drinking about nine beers per day in the evening time  
8 and that he has connected with a counsellor. So, you know, I  
9 was relieved to kind of ... well, I'm relieved to kind of get  
10 that information.

11 **Q.** And appreciating that a slowdown is all relative ...

12 **A.** Sure.

13 **Q.** ... and he's slowed down to nine beer a day, is this  
14 concerning to you as it reflects his ability to adjust coming  
15 from the military to civilian life? Nine beer a day, is that  
16 concerning?

17 **A.** Yes, absolutely.

18 **Q.** And did it appear as though he was using alcohol as a  
19 means to sort of cope with the stress he was under, the anxiety,  
20 the depression?

21 **A.** Yeah, no, that's a fair assumption, yes.

22 **Q.** Did it appear as though he had some insight into the

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1 extent of his alcohol abuse at that time?

2       **A.** There was ... I'd have to imagine that there was some.  
3 You know, he cut back and he, you know, agreed to connect with a  
4 ... he had a counsellor, so, you know, it would ... I would have  
5 to assume that there was some insight into it becoming a  
6 problem.

7       **Q.** Did you know ... were you familiar with this  
8 counsellor he had been seeing by the name of Gail MacKenzie? Is  
9 that a name you were familiar with?

10       **A.** No.

11       **Q.** Would you know who might've arranged that or did you  
12 get any idea whether Veterans Affairs had set that up or whether  
13 he set that up on his own?

14       **A.** I'm not sure. I wouldn't want to guess. It might've  
15 been through the base.

16       **Q.** Okay. And his experiences in Afghanistan, were they  
17 impacting him currently at that time?

18       **A.** Yes.

19       **Q.** And in what way?

20       **A.** So, you know, he was describing night sweats, you  
21 know, and disrupt- ... you know, sleep disruption, daily  
22 intrusive thoughts, his combat experiences, right? Feeling on

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1 guard, hypervigilant. It's difficult for him to, you know, kind  
2 of be in large centres, you know, crowded areas. And, you know,  
3 the impact on mood, right? But we're kind of getting into  
4 depression, but there is an overlap, as we know, between PTSD  
5 and depression.

6 **Q.** From a clinical perspective, he's reporting daily  
7 intrusive thoughts as it relates to his experiences in the  
8 military. Is that typical or is that sort of on the higher end  
9 of the continuum? The first time you meet with him and he says,  
10 I'm having daily intrusive thoughts. What do you make of the  
11 level in which he's reporting that intrusiveness?

12 **A.** Yeah, that's a lot. We see it, you know, in our  
13 clientele. It's ... and in times of stress, you know, there can  
14 be an increase, absolutely.

15 **(11:50)**

16 **Q.** You noted as well, in approximately middle of the  
17 report, you said, "He was difficult to redirect. Jumping from  
18 one event to another." What did you mean by this?

19 **A.** So, you know, at times, and it's more generally, he,  
20 you know, was tangential, right? He would kind of jump from one  
21 subject to the next and, you know, we sometimes see that and,  
22 you know, sometimes, you know, it may be an avoidance, just kind

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1 of not wanting to get into a specific, you know, specific  
2 details. So that's sometimes, you know, what we see as part of  
3 the presentation, and on a first session, you know, can  
4 sometimes be expected. But as ... you know, it's something that  
5 I noticed in future sessions as well.

6 **Q.** Did it appear as though this was going to, or did,  
7 pose a little bit of a difficulty in, one, trying to build a  
8 therapeutic alliance; but, two, trying to really drill down to  
9 the underlying conditions he was suffering from and how to treat  
10 them?

11 **A.** Yes to both and also just kind of staying on track,  
12 right? Staying on track with maybe what we're intending to do  
13 on the ... in the session.

14 **Q.** And I understand he reported a number of physical  
15 ailments as well?

16 **A.** Mm-hmm.

17 **Q.** And what sort of physical ailments did he complain  
18 about?

19 **A.** I don't know if it's listed here. This is a longer  
20 note, but certainly, I know that there was chronic pain, and  
21 there's an entry there that he disclosed that he fallen on his  
22 head on a few occasions and he had reported that it was never

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1 properly assessed for brain damage I see here.

2 Q. So I'm curious about this. So this concept of him  
3 falling on his head on a few occasions, did he say where that  
4 might've occurred? Was it in the military? Was it something  
5 after he's outside of a military context? Did he explain when  
6 that was?

7 A. My recollection is ... my understanding is is that it  
8 was as part of his work in the Canadian Forces, but I don't know  
9 any ... I don't recall any specifics.

10 Q. Do you recall if he initiated that conversation with  
11 you or did you sort of ask him, you know, Did you suffer any  
12 head injuries as a result of your combat or time in service?

13 A. I think he initiated it. I'm not a hundred percent on  
14 that, but I think he initiated it.

15 Q. Did you find it sort of surprising? And the reason  
16 why I ask this is that from the evidence we heard to date from  
17 the psychologist and psychiatrist in the Canadian Armed Forces  
18 is that he had never mentioned at all the possibility of a head  
19 injury or being assessed for the concerns he had, but out of the  
20 gate, the first time he meets with you, he tells you that. Were  
21 you surprised to hear that?

22 A. With the information that you're telling me right now,

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1 you know, absolutely, you know, it is surprising and, you know,  
2 not seeing anything on file to speak to that.

3 Q. How did he report being in social settings?

4 A. Guarded, right? You know, avoidant, hypervigilant.

5 Q. How would you describe his overall sort of mood or  
6 affect in this first session?

7 A. You know, I think I'd mentioned that, I think I used  
8 the word "dysthymic", so just kind of like a ... you can kind of  
9 think about Eeyore there a little bit there, just kind of like  
10 just kind of flat and just kind of, you know, just kind of like  
11 a lower grade depression. Certainly, you know, as I mentioned,  
12 you know, a bit guarded at times, and when he did open up,  
13 though, could get quite talkative and jump from one idea to the  
14 next. Very polite.

15 Q. Did you ask him about sort of any, or examine for any  
16 sort of, suicidal ideation or homicidal ideation at that initial  
17 appointment?

18 A. Yes.

19 Q. And what ...

20 A. And he had ...

21 Q. ... did you discover? Anything?

22 A. He had not reported any of either.

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1           **Q.**   How would you have normally gone about that in this  
2 particular session trying to examine whether or not he was  
3 suicidal or homicidal?

4           **A.**   Yeah, so again, you know, it's kind of like a case by  
5 case and, you know, depending on what the presentation is like,  
6 you know, the individual that's in front of me, but as I  
7 mentioned earlier, right, you start off by, you know, asking  
8 about, you know, whether he was experiencing suicidal thoughts,  
9 homicidal thoughts, right? And if it's a "yes" to that, then  
10 you kind of move on to other forms of questions, right?

11           I don't have clear recollection on exactly what I did here,  
12 but I probably wouldn't have gone into, you know, too many  
13 further questions.

14           **Q.**   How much of this evaluation of suicidal ideation,  
15 homicidal ideation, is attributable to the patient self-  
16 reporting, the information in which they're reporting to you?  
17 When you're trying to really drill down as to the level of risk,  
18 how much is dependent on what they are reporting to you at the  
19 time?

20           **A.**   You know, certainly a lot of it, you know, in my  
21 experience, and, you know, I know that there are limitations to  
22 that, right? Absolutely. You know, you're looking for the risk

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1 factors, as I alluded to earlier. You can certainly get some  
2 collateral information if that's appropriate. And you're also  
3 looking at, you know, not only what he or she is telling you,  
4 but you're also looking at, you know, the overall presentation,  
5 the demeanour, right? You know, maybe physical features, right?  
6 And is he unkept, you know, he or she unkept, right? So kind of  
7 hygiene-type of observations. And also looking at, you know,  
8 the last, you know, few days, few weeks, right? But, of course,  
9 you know, a lot of that is based on what the individual is  
10 reporting.

11 Q. You noted that you said:  
12 Client reports having few supports in the  
13 community and his family are living in and  
14 around Antigonish. He said his wife and  
15 daughter have lived there approximately six  
16 years. He is currently trying to sell his  
17 house in order to move there with them. He  
18 describes a tense relationship with his  
19 father-in-law. Other than the use of  
20 alcohol, he said another coping strategy was  
21 to keep busy with projects doing mechanical  
22 repair.

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1           So would you say, collectively, Lionel Desmond is  
2           describing marital discord, lack of community supports, he's  
3           dealing with the trauma of depression, PTSD. Would you say that  
4           when he comes to you that he is in a state of mental health  
5           crisis?

6           **A.**    I don't know if I'd use that word but there's  
7           certainly, you know, there's a lot going on in terms of mental  
8           health and in terms of situational stressors, yes, and with all  
9           these, yeah.

10          **Q.**    So would you say when he sort of, I guess, presents to  
11          you in the hand-off from Canadian Armed Forces to the OSI clinic  
12          in New Brunswick, that he is, would you say, in the high risk  
13          category, based on all of those things, to sort of spiral down  
14          or get buried in the life stressors and underlying traumas that  
15          he's trying to deal with?

16          **A.**    Yeah, you know, based on, you know, the presentation  
17          and, you know, how he's doing, the risk is, yeah, more elevated  
18          there to, like you paraphrased it there "spiral down".

19          **(12:00)**

20          **Q.**    And in the spectrum of sort of clients you would see  
21          coming from the military to an OSI clinic, where does he rate on  
22          the spectrum? I guess on the low end of the spectrum would be,

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1 I guess, the client that just has general anxiety versus the  
2 client that's very actively suicidal and uttering comments that  
3 he's going to commit suicide. Where does Lionel Desmond fit in  
4 that totality of the constellation of all those factors that's  
5 relayed to you on the first meeting?

6 **A.** Mm-hmm. You know, I'm concerned is ... I don't know  
7 if that's an okay response, right? So he's ... it is elevated.  
8 You know, given the lack of support, given that he's isolated,  
9 given the, you know, the mental health challenges and the poor  
10 coping, right? So it's ... there are significant concerns.

11 **Q.** So he expresses to you generally his views on medical  
12 marijuana, as he had been seeing Dr. Smith. Did he seem  
13 interested in medicating through cannabis at this occasion?

14 **A.** Not in this entry.

15 **Q.** So at the very bottom of the report, Doctor?

16 **A.** Yeah, yeah. So not according to this entry.

17 **Q.** And you conclude this session by saying, "Client is to  
18 be seen again next Friday (so you get him ... as you said, it's  
19 important to have the quick turnaround) during which therapy  
20 goals will be narrowed down." What did you mean by therapy  
21 goals needing to be narrowed down?

22 **A.** Occasionally, right, after that first session, you

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1 know, since it's mainly an information-gathering session where  
2 we're going over a lot of detail - the history, the current  
3 presentation - we don't get the opportunity to actually kind of  
4 flip those into concrete goals as part of the collaborative case  
5 conceptualization.

6 So in this instance, you know, we ran out of time and  
7 weren't able to kind of get into that portion.

8 **Q.** And is it fair to say that there was no way at this  
9 session that this therapeutic alliance that's so important  
10 would've crystallized at that session?

11 **A.** Fair to say, yes.

12 **Q.** Your Honour, I note it's 12. My plan is to sort of  
13 navigate through the various sessions tying in the broad  
14 concepts that we brought out.

15 **THE COURT:** Mm-hmm.

16 **MR. RUSSELL:** I'm just mindful of the witness and the  
17 court and everyone here whether or not it's the appropriate time  
18 to break now or ...

19 **THE COURT:** Well, if we break now, we're going to come  
20 back at ... do you anticipate coming back earlier or would you  
21 still come back at 1:30?

22 Dr. Murgatroyd, we have an option. We can break now or we

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1 can probably go for another half hour or so. I know that you've  
2 been seated in one spot since 9:30 or thereabouts this morning.  
3 If you'd like a break now, we could perhaps break now and come  
4 back around, oh, come back maybe about 1:15 or thereabouts?

5 **A.** Yeah, I'm okay with that, Your Honour.

6 **Q.** Does that suit your purposes? Mr. Canty, how does  
7 that work for you?

8 **MR. CANTY:** (Muted mic.)

9 **THE COURT:** It works for you too. I can read your lips.  
10 All right, thank you. So thank you, Counsel, we'll adjourn to  
11 1:15 then. Thank you.

12 **A.** Thank you.

13 **COURT ADJOURNED (12:04 hrs.)**

14 **COURT RESUMED (13:14 hrs.)**

15 **THE COURT:** Mr. Canty, Dr. Murgatroyd, you can hear us  
16 all right, can you?

17 **MR. CANTY:** Yes.

18 **THE COURT:** All right. Thank you. Dr. Murgatroyd?

19 **DR. MURGATROYD:** Yes.

20 **THE COURT:** Yes. Thank you. All right. Mr. Russell?

21 **MR. RUSSELL:** So, Doctor, where we left off you had your  
22 initial assessment and session with Lionel Desmond. So you next

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1 meet with him approximately a week later at page 79 of your  
2 report ... of the exhibit, I guess ...

3 **A.** Yes.

4 **Q.** ... New Brunswick. You document, "Intrusive thoughts;  
5 disturbed sleep, including nightly sweats; paranoia; homicidal  
6 thoughts without intent, all occur on a daily basis."

7 So would you say his presentation was much the same as when  
8 you seen him in the first encounter?

9 **A.** Yes. Yes. There's no improvement.

10 **Q.** Do you recall what the homicidal thoughts were and  
11 what they were in relation to?

12 **A.** No, I don't. Certainly, if he would have given the  
13 name of an individual or a plan or anything of that nature that  
14 would have been documented and, of course, I would have had to  
15 act out on that.

16 **Q.** Did they seem to have any connection to the stressors  
17 he was undergoing in his personal life, whether it was his  
18 employment, whether it was his relationship with Shanna Desmond?  
19 Was there any connection between those thoughts?

20 **A.** Yeah, I'm not sure.

21 **Q.** Again, you report that he had no social supports in  
22 the community. And you said, "He hardly gets out of the house

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1 because of his paranoia."

2 What sense did you get about him spending time in his  
3 house? Was it sort of considerable that he was staying inside?

4 **A.** He was quite isolated, yes. And I know that being  
5 near the base was a significant ... you know, it was a source of  
6 stress. Daily source of stress.

7 **Q.** And what was the paranoia you mentioned? "He hardly  
8 gets out because of his paranoia." What was he paranoid about?

9 **A.** You know, I ... my recollection is not clear on that,  
10 I'm sorry.

11 **Q.** And finally you state: "In any case, Mr. Desmond said  
12 he previously learned breathing techniques, relaxing with Dr.  
13 Rogers and said he does these techniques from time to time."

14 What did you know about a Dr. Wendy Rogers?

15 **A.** Well, I know that she was a psychologist who worked on  
16 base.

17 **Q.** Did you know that she had been treating Lionel  
18 Desmond?

19 **A.** Not ... not until this entry.

20 **Q.** And did you know the full extent of what sort of  
21 treatment he had been seeking from Dr. Rogers?

22 **A.** No, not ... not at that stage, not at that point.

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1           **Q.**   Were you aware ... we had Dr. Rogers testify all of  
2 yesterday and it's fair to say that she was the primary  
3 therapist and primary source of treatment for Lionel Desmond  
4 while he was in the Canadian Armed Forces. Did you know that  
5 ...

6           **A.**   Yes.

7           **Q.**   ... when you were seeing Lionel Desmond?

8           **A.**   It eventually ... he eventually brought it up as with  
9 the session, but the details ... you know, the amount of detail  
10 that he provided was limited. And, as I think I mentioned  
11 earlier, I didn't have access to the notes.

12          **Q.**   And I'm going to ask you a little bit about that,  
13 because earlier we talked about the importance of you having the  
14 information about previous treatments, previous techniques that  
15 were used, what was successful, perhaps what wasn't successful,  
16 in coming up with your own plan. Would it have been helpful if  
17 you had have had access to all of Dr. Rogers' reports, notes,  
18 treatment plans?

19          **A.**   Yes, certainly.

20          **Q.**   And can you say that you never had access to those?

21          **A.**   No.

22          **Q.**   Do you kind of know maybe why you weren't provided

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1 with those documents?

2       **A.** You know, I ... I think that the main documents that  
3 are sent over are the psychiatric files from the base, that's my  
4 recollection, and so I think that's just the routine. And in  
5 some instances they may also provide therapy notes. That wasn't  
6 the case here.

7 **(13:20)**

8       **Q.** So ideally with you and I recognize that you haven't  
9 seen her notes or reports, do you have any knowledge as to what  
10 forms of therapy she engaged in with Lionel Desmond?

11       **A.** No.

12       **Q.** If I told you that she had engaged in prolonged  
13 exposure therapy quite frequently with him, would that  
14 information kind of assisted you in coming up with your own  
15 treatment program as it relates to Mr. Desmond?

16       **A.** Yes, it would have been helpful.

17       **Q.** And helpful in what way?

18       **A.** Well, even if we ... because we know that there can be  
19 a recurrence of symptoms, right, and you know, if he ... again,  
20 if we're going into the modalities that he's ... you know,  
21 treatment modalities that he has, you know, engaged in in the  
22 past, what was helpful/what was less helpful, you know, that can

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1 help us out with the action plan.

2 Q. And would it have been helpful for you to know where  
3 they left off when they concluded that treatment?

4 A. Yes.

5 Q. And is that something you could have discussed with  
6 Lionel Desmond as to how he felt that treatment, whether it was  
7 helpful to him or not?

8 A. Yes. And, you know, obviously what we're not seeing  
9 here ... seeing it here on the note, and I'm not sure through  
10 recollection whether we had that discussion.

11 Q. And ...

12 **THE COURT:** Now ... I'm going to stop you for a second  
13 ...

14 **MR. RUSSELL:** Yes. Yes, Your Honour.

15 **THE COURT:** ... Mr. Russell. Dr. Murgatroyd, I'm just  
16 going to interject for a minute here and ask you a question.

17 If you had been aware that prolonged exposure had been the  
18 therapy treatment that had been used by Dr. Rogers, and if you  
19 were aware that it had had some degree of success, and  
20 appreciating that when Cpl. Desmond was then referred to OSI,  
21 and also appreciating that that's ... that was not necessarily  
22 your preferred treatment modality, if PE had been ... had some

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1 level of success, would that have affected or influenced the  
2 clinical psychologist that may have been assigned to deal with  
3 Cpl. Desmond?

4 **A.** Yes, Your Honour, it may have, right. You know, that  
5 information, you know, may have been helpful. I can speak for  
6 myself, I think that that would have been helpful absolutely in  
7 determining the next few steps.

8 **THE COURT:** All right. And in the normal course of  
9 events when someone is referred from the base by ... in this  
10 case it was Dr. Joshi, and there are some psychiatric ... at  
11 least his reports come to you, are you able to make a request  
12 for any clinical psychologist's notes and in fact all of the  
13 clinical psychologist's notes so that you can have access to  
14 them?

15 **A.** That's a request that could be made in, you know,  
16 getting the proper consent and, you know, or a summary of the  
17 notes. Because, yeah, tend to be more notes given the higher  
18 level of contact as was discussed.

19 **THE COURT:** And do you know who it is that takes on the  
20 responsibility of deciding what documents are sent as part of  
21 the referral from the CF health records to OSI? Do you know how  
22 that's determined?

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1           **A.**    I'm ... I'm not really sure, no.

2           **THE COURT:**     Okay. All right, that's fair. And it may  
3 be not something that you'd be particularly tuned into at any  
4 rate, so. Sorry, Mr. Russell. Go ahead. Thank you, Doctor.

5           **MR. RUSSELL:**    There was just one point ...

6           **A.**    Thank you.

7           **Q.**    ... that I would wish to clarify. So, Doctor, I just  
8 want to get this straight.

9           **A.**    Mm-hmm.

10          **Q.**    You'd indicated earlier in your testimony your  
11 preferred choice of therapy that you use in many contexts as it  
12 relates to PTSD, and was it prolonged exposure therapy is your  
13 preferred method?

14          **A.**    Yes.

15          **Q.**    Okay.

16          **THE COURT:**     Oh, it was. I'm sorry. Thank you.

17          **MR. RUSSELL:**    But in either case the answers are still the  
18 same as it relates to the information would have been helpful?

19          **A.**    Yes. Yes, absolutely.

20          **Q.**    And just to conclude on this session. You note on  
21 your report you say: "Mr. Desmond was visibly distressed by the  
22 thought of doing trauma work at this time. He became distant

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1 and did not wish to speak for several minutes during the  
2 session."

3 So, were you having trouble sort of getting this off the  
4 ground, I guess, so to speak?

5 **A.** Yeah. You know, in re-reading this note I'm kind of  
6 brought back to this moment, right, where bringing up, you know,  
7 the idea of engaging in trauma-focussed therapy certainly  
8 triggered something, you know, a distress in Mr. Desmond at that  
9 point, right. And so he ... as I indicate in this note there,  
10 he kind of fell silent for a few moments, which suggested there  
11 that, you know, it's ... it may be a little bit too early to  
12 kind of get into that.

13 **Q.** Sure. There's one other aspect, I apologize. You  
14 noted that he had been dealing with a number of stressors and  
15 you noted that dealing with VAC, Veterans Affairs Canada, and  
16 multiple health professionals was a cause of stress for him.

17 What was it about Veterans Affairs Canada and other  
18 healthcare professionals that was causing him some difficulty  
19 and stress at that time, do you recall?

20 **A.** I don't. I wonder too if it was just, you know,  
21 dealing with multiple, you know, agencies, multiple people, just  
22 the totality, but I don't recall any specifics.

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1           **Q.**   And from your testimony earlier I understand that  
2 Marie-Paule Doucette, his ultimate case manager with Veterans  
3 Affairs, may not have been in place when Lionel Desmond first  
4 became involved with you at the OSI?

5           **A.**   Right. Yeah, so it would have been later I believe in  
6 20- ... so I guess 2015. So who he was dealing with at VAC at  
7 that point, you know, might have been, you know, just other, you  
8 know, members of Veterans Affairs. He was probably not assigned  
9 yet ...

10          **Q.**   So did you have a contact ...

11          **A.**   ... but still having to ...

12          **Q.**   Did you have a contact person with Veterans Affairs as  
13 it relates to Lionel Desmond at this point that you could reach  
14 out to and discuss things?

15          **A.**   No, not ... not that I recall.

16          **Q.**   And there was no information provided to you to say if  
17 you want to discuss Lionel Desmond and his treatment with  
18 Veterans Affairs, because we know there was the consent to  
19 sharing the information, at this point did you have any idea who  
20 that would have been?

21          **A.**   No, but we can ... there's always somebody that can  
22 ... that you can ... you know, on-call let's say, right, that

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1 you can reach out to if there isn't an assigned case manager.

2 Q. Okay. So if we turn very quickly to page 78, my  
3 understanding that Lionel Desmond has now missed his third  
4 scheduled session for July 10th. He's unable to make his  
5 appointment, is that correct?

6 A. 7th or 9th?

7 Q. He has a scheduled session for July 10th, and I  
8 believe you speak to him on July 9th and he says ... he tells  
9 you ...

10 A. Oh, right.

11 Q. ... that he's not going to make the session. Do you  
12 recall that?

13 A. He's cancelling the appointment.

14 Q. And what was the purpose for why he cancelled this  
15 appointment?

16 A. So he had decided to return home to Antigonish. He  
17 wanted to spend some time over there with his family and I  
18 indicate here to kind of clear his mind ...

19 Q. You noted ...

20 A. ... and just kind of take a bit of a break, yeah.

21 Q. So is this sort of the first indication you're getting  
22 of Lionel Desmond? So now he's missed, you know, two of three

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1 sessions and you're getting a sense that he's going back and  
2 forth between provinces.

3 Was this sort of recurring theme throughout his treatment  
4 that he'd be in Nova Scotia, then he'd be in New Brunswick, back  
5 and forth?

6 **A.** That is a recurring theme. At this stage it wasn't  
7 clear yet because this was the first instance but, yeah, that's  
8 a good way of summarizing it.

9 **Q.** And ultimately did you feel as though that that was  
10 sort of getting in the way of sort of gaining traction to even  
11 get to starting treatment with him because he was so transient  
12 back and forth between the provinces?

13 **(13:30)**

14 **A.** Yeah. In terms of, you know, committing to an  
15 engagement, it was, you know, interfering with the therapy  
16 process.

17 **Q.** And I understand you had ... given that he said he was  
18 headed back to Nova Scotia, going to miss his appointment, you  
19 were prepared to offer him contact by phone. Was he receptive  
20 to that idea, initially?

21 **A.** I'm seeing here "no".

22 **Q.** What did he sort of indicate?

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1           **A.**    And I don't ... I'm not sure. You know, I'm kind of  
2 just going back, based on the last couple of sessions. But I  
3 don't know if there's just this resistance, you know, being kind  
4 of unsure that he wants to kind of jump into this. But I'm ...  
5 you know, that's speculation a little bit. I'm not entirely  
6 sure.

7           **Q.**    Okay. So you leave ... you conclude that session, I  
8 understand, where he says he'll contact you in a month's time  
9 when he returns to New Brunswick. Is that right?

10          **A.**    Yes.

11          **Q.**    And if we turn to page 76 ... so the last time it  
12 appears you spoke to him was July 9th. He was headed back to  
13 clear his mind in Nova Scotia. Is it fair to say that you don't  
14 hear from him for several months; in fact, you don't hear from  
15 him August, September, and the majority of October until October  
16 23rd, 2015?

17          **A.**    Yeah. Yeah. You know, in reviewing the file, I was  
18 quite surprised at the amount of time there.

19          **Q.**    So had Lionel Desmond had any contact with you or, to  
20 your knowledge, the OSI Clinic between the three-month period  
21 between July 9th, the phone call with you, return to Nova  
22 Scotia, and October 23rd, 2015?

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1           **A.**    He had attended his appointment with Dr. Njoku on  
2 August 31st and that's something that I would have been aware of  
3 at the time and his assessment.  Yeah.

4           **Q.**    And where you left off, you had stated that he was  
5 having homicidal, suicidal, and paranoid thoughts on a daily  
6 basis, and it was important to see him biweekly or weekly.  Did  
7 you have concerns that for a three-month period there was no  
8 contact with you?

9           **A.**    You know, when you put it that way, certainly I ...  
10 you know, there were concerns.  The last time I had spoken with  
11 him, which was on July ...

12           **Q.**    9th, I believe.

13           **A.**    ... 9th, things seemed to be going better for him.  
14 So, you know, that was a relief, you know, compared to, you  
15 know, session two.  But, certainly, look, more from a just  
16 therapy engagement and kind of commitment standpoint, I was  
17 concerned.  And, of course, you know, him attending Dr. Njoku's  
18 appointment, Dr. Njoku having an opportunity to meet with him,  
19 you know, it was a relief.

20           **Q.**    And I'm just going to ask you about Dr. Njoku.  In  
21 your note from October 23rd, you indicated that: "Lionel Desmond  
22 indicated that he comes to New Brunswick about once a month.  I

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1 asked him about the appointment he cancelled with Dr. Njoku,  
2 September 29th."

3       **A.** Yeah.

4       **Q.** So he cancelled that appointment with Dr. Njoku. He  
5 had one in August but he cancelled one in September as well?

6       **A.** Yes, according to this.

7       **Q.** Did he provide you with any sort of explanation as to  
8 why he was cancelling the appointment with Dr. Njoku?

9       **A.** I see here that he was worried about being forced to  
10 go to Montreal, as the program at Ste. Anne's had been discussed  
11 at that initial appointment with Dr. Njoku.

12       **Q.** So his initial reaction ...

13       **A.** And that might have been ...

14       **Q.** Go ahead.

15       **A.** That might have been part of the reason why he  
16 cancelled. Yeah.

17       **Q.** Did you get a sense ... and I noticed that it was you  
18 that reached out to him in October, after three months, did you  
19 get a sense that his condition was such that it was causing him  
20 sort of avoidance or an inability to stay on track when it comes  
21 to maintaining appointments that were important to his mental  
22 health?

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1           **A.**    Yes.  You know, certainly, you know, the inconsistency  
2  there, the cancellations ... and, you know, we have here with  
3  this entry, right, that you're just kind of like that ... that  
4  worry about, you know, something more intensive in Montreal and  
5  so, yeah, avoidance.

6           **Q.**    And I believe you had some discussion with him  
7  regarding how his relationship with his wife had been going and,  
8  I guess, how did he describe that?

9           **A.**    I'm basing it on the note here.  I don't have a clear  
10  recollection as to what was going on.  You know, that he wanted  
11  to spend time with his family, his wife and daughter, reports  
12  that things were up and down.  I'm not really clear on what that  
13  means specifically.

14          **Q.**    This appears to be the first time that you turn your  
15  mind to resources in Nova Scotia.  You note in this report, you  
16  say: "I told him that we would be transferring his file over to  
17  the OSI Clinic in Halifax."  My understanding is that, at the  
18  time, there is no official Nova Scotia OSI Clinic in operation.  
19  What clinic are you referring to?

20          **A.**    Right.  And, yeah, that ... you know, I guess we could  
21  call that maybe a mistake there on the file.  That would be a  
22  satellite clinic that was located in Halifax at the time and

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1 they were associated to us ... with us. In ... my understanding  
2 is that the two ... there are two ... a nurse and a psychologist  
3 that we would regularly have contacts with ... actually, they  
4 met with us on a weekly basis for our IDT meeting,  
5 interdisciplinary team meeting. And so my understanding is that  
6 they were employed by our clinic, by Horizon. And so, you know,  
7 he would get connected there. But I guess, technically, he'd  
8 still be connected to our clinic, just being ... getting  
9 services in Halifax.

10 Q. So why was it sort of ... at this point now, you're  
11 turning your mind to the importance of him having a connection  
12 in Nova Scotia. Why was that important? Or access to resources  
13 in Nova Scotia?

14 A. Yeah. Well, we were ... well, I say "we". I'm pretty  
15 sure Dr. Njoku, as well. You know, we were concerned with his  
16 inconsistency in that, you know, we're talking, you know, two,  
17 three months now in the Antigonish area, that may be a referral  
18 or a transfer, you know, would be appropriate. It's a shorter  
19 distance.

20 Q. Do you know if ... did you have any conversation with  
21 Veterans Affairs regarding the possibility of accessing the  
22 satellite office in Nova Scotia and why that might be helpful?

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1           **A.**    I don't know about exactly at this stage, but  
2 certainly it was discussed in the coming weeks.

3           **Q.**    Okay.  So if we turn to page 70 ...

4           **A.**    70?

5           **Q.**    70, yes.  So this is on October 30th of 2015.  It's a  
6 phone call that Lionel Desmond makes to you.  It's regarding an  
7 occurrence where he talks about being admitted to the DECH  
8 Psychiatry Unit in Oromocto.  What is the "DECH" Unit?  Do you  
9 know what that is?

10          **A.**    Yeah.  It's the Dr. Everett ... I think there's an "R"  
11 ... supposed to be an "R" in there, Regional Chalmers Hospital,  
12 or something like that.  It's in Fredericton and it's the  
13 hospital in Fredericton.  That's the acronym.  And so, yeah,  
14 admitted to the psychiatric unit.

15          **Q.**    And I ...

16          **A.**    The ...

17          **Q.**    And I understand this comes about as a result of a  
18 conversation he's relaying to you of a conversation he had with  
19 his wife on ... of that previous Friday where he might have  
20 suggested that he was going to commit suicide.  Is that correct?

21          **A.**    Yes.  That was the situation.

22          **(13:4)**

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1           **Q.**   How did he sort of characterize the circumstances?

2           **A.**   So according to him, you know, he ... as he was ending  
3 the phone call, he said, Good night, goodbye. This is what I've  
4 got here. And, according to him, it was just ending this  
5 conversation. This is what he's telling me. Her interpretation  
6 was, you know, different, that he ...

7           **Q.**   Did he relay to you that he ...

8           **A.**   ... he was at risk.

9           **Q.**   Did he relay to you that he advised her that he was  
10 going to write her out of his will?

11          **A.**   That's what I see here.

12          **Q.**   And did this give you sort of any concern for his  
13 perhaps risk for suicide?

14          **A.**   Certainly, it raised some concerns. It ... you know,  
15 I was relieved that, you know, he was taken in and assessed.

16          **Q.**   And, again, this is over the phone.

17          **A.**   Uh-huh.

18          **Q.**   How's the level of intensity of his PTSD symptoms at  
19 this time, as well?

20          **A.**   He's reporting that, you know, his symptoms are  
21 intense. Right? He describes, you know, his mind is constantly  
22 racing. And he's ... it seems like he's opening up to this idea

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1 of connecting to a more intensive program.

2       **Q.** So his ... is it fair to say his views have sort of  
3 shifted? Originally, he was worried that he was going to get  
4 referred to the Ste. Anne's program but now does he seem  
5 receptive to the idea and recognizing the importance?

6       **A.** Yeah. It's seems so, just based on, you know, the  
7 increase in distress and his PTSD symptoms.

8       **Q.** So if we turn to page ... so I guess at this point,  
9 we're at the end of October, and the last time you would have  
10 seen him in person was July ... June or July?

11       **A.** Is it okay if I just say something?

12       **Q.** Sure.

13       **A.** I think there might have been an error, you know, just  
14 kind of a mistake when it comes to what I entered, and it might  
15 help with the timeframe a little bit. I think it was meant to  
16 be November 30th here and not October 30th.

17       **Q.** Okay. So the period of time is further. So it's  
18 November 30th when you speak to him.

19       **A.** On this occasion. Right. Yeah.

20       **Q.** Okay.

21       **A.** So the next entry is December 3rd. Right? So it  
22 would have been shortly after that incident.

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1           **Q.**    Okay.  So what was previously referred to as occurring  
2  on October 30th, which was the call about being admitted to the  
3  psychiatric unit, that was actually November 30th?

4           **A.**    Well, that's my assumption, right, just based on all  
5  the previous notes.  Because there's a few entries there in  
6  November.

7           **Q.**    Okay.

8           **A.**    In reviewing the file, in preparing there, that kind  
9  of caught my attention.

10          **Q.**    Sure.  So I guess previous to him disclosing what he  
11  disclosed to you on November 30th, if we go back a few weeks to  
12  page 75, which is November 9th, there's another call from him.  
13  And I believe this call, he's also in distress?

14          **A.**    Yes.

15          **Q.**    And what was the source of his distress when he's  
16  calling you?

17          **A.**    So this was a situation where he ... his wife had  
18  purchased tickets, you know, to go visit her sister in Regina  
19  over the holidays.  And, at the time, it seemed like ... it  
20  seemed to him that she bought tickets for herself and their  
21  daughter but not him without discussing plans.  And so that was  
22  a source of the stress.  And he had concerns over the finances

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1 and being able to pay the bills and so he was worried. So that  
2 was a source of the stress during this phone call.

3 Q. And when you say ...

4 A. And he was ... yeah.

5 Q. And when you say he was in distress, what do you mean  
6 by that?

7 A. Over the phone you can kind of tell that he's  
8 agitated, that he's, you know, frustrated. There's anger. So  
9 ...

10 Q. And did he feel as though he was being supported by  
11 his wife and her family as it relates to his mental health?

12 A. I see that in this entry there, he, you know,  
13 identified, you know, not ... his wife and her parents being  
14 unsupportive of his mental health concerns. So he did report  
15 that.

16 Q. So I'm looking at your note and it ... as a rule, it  
17 starts with, he calls, he's in distress, he's upset about plane  
18 tickets, he's upset about money, he's going to separate the  
19 accounts, he's upset about bills, he's upset with his wife and  
20 her parents, he feels they're not supportive or sensitive to his  
21 mental health concerns. And then it notes: "Mr. Desmond  
22 admitted to having fleeting homicidal thoughts, but no intent."

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1 What sort of homicidal thoughts was he having, in that context,  
2 in that discussion? What was it in relation to?

3 **A.** Right. Yeah. And, again, if he would have identified  
4 an individual or, you know, a plan or anything like that, you  
5 know, that would have been identified, but ... or noted. But,  
6 you know, that wasn't identified and so ... you know, that's  
7 just kind of part of the assessment. Right? You're looking at  
8 various questions. You're looking at various risk factors. But  
9 at that time, he identifies that, you know, there were fleeting  
10 thoughts. You know, he's not ruminating on this. He's not ...  
11 you know, he's not planning anything out. There is no intent.

12 **Q.** And I understand, Doctor, very clearly that you  
13 certainly ... this is well in advance of the tragic events and  
14 you certainly didn't have any crystal ball to see into the  
15 future. But I'm really trying to drill down on when someone is  
16 ... when you're documenting that someone is having homicidal  
17 thoughts, kind of ... from my background, a homicidal thought  
18 seems to be a thought of harming someone or killing someone.

19 **A.** Uh-huh.

20 **Q.** When you document "homicidal thoughts", is that what  
21 you're referring to, that he had a thought of killing someone?

22 **A.** Right. And, you know, maybe we'll get to this a

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1 little bit later on. You know, upon clarification later on,  
2 right, in a later entry, we discussed this, he and I.

3 Q. Yes.

4 A. And it ... he seemed to be talking about ... or, you  
5 know, referring to violent thoughts and homicide scenes from  
6 overseas.

7 Q. Okay.

8 A. So it's ... obviously, you know, you're kind of  
9 reviewing the file and all that. I don't remember this  
10 particular occasion given on, you know, November 11th ...  
11 November 9th. But clarifying that at a later time, it seems  
12 like he is referring to what sounds like intrusive thoughts,  
13 right, that are more ... you know, secondary to his PTSD. So I  
14 don't know if that answers your question.

15 Q. No. That's fair.

16 A. I know what you mean by ... yeah.

17 Q. I sort of just wanted to put it in context to try to  
18 understand, where it wasn't documented, what the homicidal  
19 thought was in relation to and in what sort of ...

20 A. Yes.

21 **(13:50)**

22 Q. ... context. Because at the next line it says: "He

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1 said he would not hurt anyone. Indicated that his daughter  
2 remains his number one priority." So how is it going with the  
3 referral to Nova Scotia satellite clinic at this time?

4 **A.** I don't recall the specifics. You know, there was an  
5 attempt ... there was contact with Christine Lillington, who  
6 again was a nurse that was affiliated with OSI Fredericton but,  
7 you know, stationed in Halifax, to kind of get the ball rolling  
8 or at least have a conversation. And it seemed like she was  
9 going to be reaching out to him. And it looks like that didn't  
10 happen or, you know, he was unable to receive that call.

11 **Q.** Okay. So just to put this in context, so last time  
12 you would have seen him in person was July 3rd of 2015. This  
13 phone call is now November 9th of 2015. So we're four months  
14 into his contact with you. Is it fair to say that you are still  
15 unable to even begin any sort of treatment with him?

16 **A.** Absolutely.

17 **Q.** And what do you think ...

18 **A.** Yes.

19 **Q.** ... was getting in the way of you even starting  
20 treatment with him or getting to it over that four-month period?  
21 What do you think was blocking it?

22 **A.** Well, frankly, several things. I think, you know,

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1 probably the number one thing is being in Antigonish. You know,  
2 so not having, you know, that physical presence; you know, the  
3 ... because it's ... typically, we're meeting with folks in  
4 person. Right? And then, of course, you know, kind of stress  
5 after stress and it seemed like we were kind of putting out  
6 fires, right, rather than actually working on actual  
7 intervention.

8 So, you know ... so him not being here, the lack of contact  
9 ... you know, we're not ... even over the phone, it's not very  
10 regular. And then, you know, kind of stressor after stressor  
11 there, just kind of dealing with stresses.

12 **Q.** And how was the therapeutic alliance going along?  
13 Were there sort of struggles with that, as well, given the  
14 nature of what you indicated?

15 **A.** It's hard to say. You know, I certainly, you know ...  
16 he was calling from time to time. I mean that, I imagine, is a  
17 good thing. But, you know, that trust, I don't know that it was  
18 necessarily there and, you know, I think it still needed some  
19 work.

20 **THE COURT:** Mr. Russell ... so, Doctor, as I understand  
21 it, also during that course of time, his initial reaction to the  
22 possibility of going to Ste. Anne's was to kind of avoid

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1 appointments and by, at least that December 14th, which is at  
2 page 67, it appears that he is now looking at Ste. Anne's as a  
3 kind of a priority because his ... sorry, something he was  
4 prepared to do because his priority was to get treatment. Would  
5 you view that as ... seems to me that's a turn in attitude, at  
6 least in terms of his ... the way he's looking at Ste. Anne's.

7 **A.** Yeah, absolutely, I'd agree with you, Your Honour.  
8 And, you know, I know we're not also looking at Dr. Njoku's  
9 notes. I don't know if, at that point, he would have met with  
10 Dr. Njoku again and maybe they would have discussed it again.

11 **THE COURT:** Right.

12 **A.** But certainly a change in attitude.

13 **THE COURT:** Yeah. Thank you.

14 **MR. RUSSELL:** Dr. Murgatroyd, if you could turn to page  
15 99. It's Exhibit 244, again. There's a document and it's  
16 titled, "Case Consultation at IDT." What is "IDT"?

17 **A.** So that's the interdisciplinary team meeting. At the  
18 time, we would meet on a weekly basis, the whole team and Dr.  
19 Njoku and I. And it's an opportunity for the team to, you know,  
20 discuss cases, right, you know, with the whole team. And, you  
21 know, another, I guess, benefit of having that, you know,  
22 multidisciplinary team there, I'm answering that question from

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1 earlier, kind of ... you've got a wealth of experience there and  
2 so kind of bouncing off ideas. Those meetings were also when we  
3 would look at the treatment wait list and the psychiatry wait  
4 list. And if ... you know, if we feel that we're able to, you  
5 know, pick up a client or two, that's when that would occur.

6 So Dr. Njoku and I decided to bring this ... bring Lionel's  
7 situation to the IDT meeting just because ... yeah, well as is  
8 indicated here, right, managing the current situation, the in  
9 between Oromocto and Antigonish and, you know, there are  
10 stressors. We're concerned. And so we wanted to check with the  
11 team to see what their thoughts were; you know, whether it would  
12 make sense to make the transfer now as had been ... you know, we  
13 had been kind of talking about all of this, you know, Dr. Njoku  
14 and I, even connecting with Christine Lillington.

15 Ultimately, the team recommended that, you know, given that  
16 the client had, you know, some sort of alliance, right, contact  
17 at least, with us that he, you know, should remain, you know,  
18 with the OSI Fredericton team for the time being.

19 **Q.** So ...

20 **A.** And booking telephone sessions whenever he's in  
21 Antigonish.

22 **Q.** So it became sort of a recognized concern, this sort

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1 of transient back and forth nature. And as inconsistency with  
2 attending in person, it sort of came to a head where you guys  
3 actually had a conversation and a conference to sort of ...

4 **A.** Yes.

5 **Q.** ... discuss how you were going to approach it. I  
6 notice ...

7 **A.** Yes.

8 **Q.** ... at the bottom, under "Plan", it says, "Contact  
9 client to make him aware of the plan. Contact Veterans Affairs  
10 Canada to find out if case manager was assigned." So, to your  
11 knowledge, was there any Veterans Affairs case manager at this  
12 point? We're now in late November 2015.

13 **A.** I'm not sure. So I think that was part of, you know,  
14 the plan here to check that out and, you know, the importance of  
15 having, you know, a case manager just given, you know, exactly  
16 what you described earlier there, just the inconsistency and,  
17 you know, having another person onboard here. Because it's not  
18 all, you know, veterans that have an assigned case manager,  
19 because some might not need a case manager. But, certainly, in  
20 his case it was something that was needed and would be part of  
21 ... I forget my train of thought there, but would be helpful.

22 **Q.** So I understand, I mean as his clinical psychologist,

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1 you're part of an entity that's offering a valuable service to  
2 him. But, at the same time, is it fair to say that you needed  
3 to rely upon another resource and Desmond perhaps needed to rely  
4 on another resource to help him sort of bridge that gap between  
5 the help and getting to the help?

6 **A.** Yes. That's a good way of summarizing it. Yes.

7 **Q.** And, in your mind, was that sort of Veterans Affairs  
8 could have been that entity which facilitated that bridge?

9 **A.** Yes. Yeah. No, so that's part of their role. Right?

10 **Q.** And that was ... was that the purpose for bringing  
11 case manager into the conversation of this IDT meeting on  
12 November 19th, 2015?

13 **A.** Yeah. It would have been part of the discussion.  
14 Yeah.

15 **(14:00)**

16 **Q.** So I'm just trying to get the sequence of the entity.  
17 So we have Canadian Armed Forces makes a referral to the OSI  
18 clinic. The patient becomes discharged from that entity in  
19 June. Now falls under Veterans Affairs Canada. Did anyone from  
20 Veterans Affairs Canada contact you, as his primary treating  
21 therapist, between June and the end of November and say, I hear  
22 you have one of our members here. How are things going?

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1           **A.**    Not to my knowledge.

2           **Q.**    Would it have been helpful if you had a contact with  
3 Veterans Affairs Canada very early on, as soon as June, when you  
4 started seeing Lionel Desmond?

5           **A.**    Like in the spirit of, you know, just kind of like a  
6 team approach, right? And then kind of having everybody on the  
7 same page? Yes, absolutely. And, of course, I don't know what  
8 there ... you know, I know they have wait lists and wait times  
9 as well, so I don't know what that looks like.

10          **Q.**    That's certainly fine, Doctor. So then turn to page  
11 71 and this is session number four. It appears as though you  
12 met with Lionel Desmond in person on November 27th. I just want  
13 to ask you a little bit about, there's a mention here that he  
14 says he's going back to Antigonish because it's too stressful at  
15 this time. But then you also indicate that, "Today we talked  
16 about some of his basic needs, some of which he does not appear  
17 to be fully meeting at this time." What appeared to be lacking  
18 on his basic needs at the end of November when you met with him  
19 at this session?

20          **A.**    You know, I mean one of the things that we look at,  
21 you know, early on is just the day-to-day routine, right, and  
22 activities of daily living. And I couldn't believe it, you

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1 know, when he gave me that estimate that he was only eating  
2 about 600 calories a day. So I was quite worried about  
3 nutrition. I was just worried about whether or not he was  
4 taking care of himself, right? And he'd ... at the session, I  
5 remember this. He asked to get weighed and we actually did that  
6 in the, we have a medical room there and so, you know, one goal  
7 that we kind of decided to work on there was just seeing if we  
8 ... he can kind of improve that.

9 Q. And in terms of the other one was an indication of a  
10 lack of funds. Did you explore that with him, what was going on  
11 there?

12 A. Oh right.

13 Q. It said: "Lack of appetite and lack of funds."

14 A. Mm-hmm.

15 Q. Did it appear as though he was struggling financially?

16 A. Yes. I mean it was something that he brought up on a  
17 regular basis, you know, we just kind of talked about the  
18 situation with Regina, so it was a source of stress that he  
19 would bring up. I don't recall this particular entry.

20 Q. And I guess it's one thing to ... I'm going to ask you  
21 a question. It's one thing to assume someone that has mental  
22 wellness, if they're able to keep on top of their basic needs,

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1 manage their funds, manage their affairs, manage their  
2 appointments, but knowing Lionel Desmond in the way you did, and  
3 knowing his condition and underlying ways in which it was  
4 affecting him, would he have needed someone to assist him in  
5 navigating those basic needs? Would it have been helpful?

6 **A.** Yeah. I mean I think so and I think that was  
7 discussed not too long after this, you know, in terms of  
8 Veterans Affairs has resources, clinical ... we call them  
9 clinical case managers or clinical care managers, where, you  
10 know, we make that recommendation. And these are individuals  
11 that kind of do the hands-on, will go out and meet the  
12 individual at, you know the veteran's place and, you know, might  
13 be able to help with more hands-on needs. But certainly,  
14 because of the presentation and just kind of him voicing, you  
15 know, some of these concerns himself, you know, we know that  
16 with depression or PTSD, you know, sometimes we're not taking  
17 care of ourselves.

18 **Q.** To your knowledge, did he have any clinical care  
19 manager between the referral and intake of early May 2015 and  
20 the end of November 2015?

21 **A.** In the end, and I don't know for what reason exactly,  
22 I don't think we ended up making that referral. My

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1 understanding is that that was being set up, well at least I got  
2 that message that he was getting that set up in Nova Scotia in  
3 late 2016. I don't know if that happened.

4 **Q.** And, Doctor, if you could turn to page 69, this is a  
5 session five from December 3rd of 2015. During this session,  
6 there's a mention that you were going to make a referral of Mr.  
7 Desmond to the OSISS peer support program. What is that?

8 **A.** So that is the OSI social ... I'm trying to remember  
9 the acronym here. Social support network, I believe. So it's a  
10 peer support program. I think I mentioned it a little bit  
11 earlier on. It's for military veterans and their ... who have  
12 an OSI and their families. There are coordinators for both the,  
13 you know, for the programs for the veterans and there's, I  
14 remember at the time, a coordinator for the family members. And  
15 so they, at the time, I recall, would meet I think a couple of  
16 times a week. You know, one of those meetings, a lot more, you  
17 know, kind of like a familiar setting. Going for a coffee and  
18 just an opportunity to kind of just get together and, you know,  
19 just, you know, talk about the weather, you know. And then the  
20 other meeting would happen more kind of like a support-  
21 structured environment, you know, with people kind of getting  
22 into a circle and maybe talking about how it's going with their

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1 week. And so it's a really nice service, a nice program that we  
2 will refer our clients to.

3 **Q.** And is this something you thought would be of value to  
4 Lionel Desmond?

5 **A.** Yeah. You know, it's kind of the comradery, the  
6 support, right? He was quite isolated in the Oromocto area,  
7 right? So we're talking about a bunch of veterans led by, you  
8 know, Glenn Park. He's a veteran himself, so led by Glenn Park.  
9 And so we felt that that was a good option and made that  
10 suggestion.

11 **Q.** Do you know if Lionel Desmond ever did get the  
12 referral to that group? Did he ever participate in the group as  
13 well?

14 **A.** I don't believe so. And it's unclear here. I wish  
15 there was a little bit more information whether I reached out to  
16 Glenn myself. I know I gave the contact number to Mr. Desmond.  
17 I think there's a later entry there that I checked in to see if  
18 had contacted him and it seemed he had not.

19 **Q.** And if, say, you were aware that Lionel Desmond had a  
20 clinical care manager, would you have passed on that information  
21 to that person as well as opposed to just giving Lionel Desmond  
22 the number?

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1           **A.**    I suppose that could be an option.  You know,  
2   certainly, you know, we kind of worked on that accountability,  
3   you know, and I know that we've got an individual here that, you  
4   know, was experiencing, you know, a lot of mental health  
5   challenges, right?  So ... and avoidance, you know.  So that can  
6   help explain maybe the lack of follow through.  So in this case,  
7   yeah, you know, maybe it would've made sense to have that  
8   conversation with a clinical care manager.

9   **(14:10)**

10           **Q.**   And if we could turn to page 68.  So I understand  
11   Lionel Desmond misses his third appointment.  He cancels that  
12   appointment.  What are his views on being involved in attending  
13   Ste. Anne's and the referral to the St. Anne's program?  Is he  
14   receptive to that idea?

15           **A.**    Yeah.  According to this note, absolutely.  So it was  
16   positive, you know, that he's still expressing that.

17           **Q.**    And I'm wondering if we could turn to page 67.  
18   December 14th, you have a phone conversation with him where you  
19   note:  "He said that getting better is his priority and so he  
20   wants to go to treatment.  He stated that he's willing to stop  
21   taking marijuana."  Was there some discussion about a  
22   prerequisite that he come off of cannabis consumption before he

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1 enrolled in the program?

2       **A.** Yes, that was one of their conditions at the St.  
3 Anne's program. I'm trying to remember. Maybe four weeks, six  
4 weeks - something like that - prior to admission.

5       **Q.** Did he appear to be committed to doing, I guess, what  
6 was required of him so he could be able to attend the program  
7 should it come available?

8       **A.** He describes a willingness here which ... you know,  
9 and he's even mentioning here that he'd already kind of looked  
10 up the information, you know, was a good sign.

11       **Q.** If we could turn to pages 96. I guess, in particular,  
12 97. So do you recognize this document, Doctor?

13       **A.** Mm-hmm.

14       **Q.** And this is a letter, I believe, from December 15th of  
15 2015. What is it?

16       **A.** Sorry, what ... 96, 97, yeah?

17       **Q.** Yes. So what is this?

18       **A.** So this is a ... yeah, so I've ... it's a  
19 recommendation letter that is sent to the attention of Marie-  
20 Paule Doucette, Lionel's case manager, for Ste. Anne's, the  
21 program in Ste. Anne's. It was a recommendation letter that we  
22 wrote.

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1           **Q.**   And you note in the recommendation letter at the very  
2 top: "This letter is to strongly recommend admission." Why was  
3 Lionel Desmond strongly recommended in terms of his attendance  
4 at the Ste. Anne's program?

5           **A.**   You know, just given, you know, as was mentioned in  
6 the next sentence there, the chronic PTSD there, the  
7 presentation, right? I think we talked a little bit about how  
8 stabilization is needed to be able to, you know, do the  
9 treatment, you know, do the therapy justice, right? And so with  
10 the inconsistency, with the back and forth, with the lack of,  
11 you know, commitment and engagement, right, part of that is, you  
12 know, that we haven't been able to kind of properly stabilize  
13 the client, right? And so he is ... a program like the one  
14 offered in Ste. Anne's is an intensive program, right? So we're  
15 able to, you know, kind of remove that individual, so to speak,  
16 from, you know, the stresses of daily life, right? And it  
17 doesn't always work that way, but for some, right, it's just  
18 kind of like a bit of an escape. And then we really kind of put  
19 the focus on, you know, skills building and the stabilization to  
20 do ... to then graduate to further intervention.

21           **Q.**   So in your opinion, and is it fair to say that the  
22 first step here in Lionel Desmond's move forward in terms of his

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1 mental health was stabilization?

2 **A.** Yes, absolutely.

3 **Q.** And in your clinical view, clinical judgement, was he  
4 stabilized at any point between the seven months of May,  
5 referral to the OSI in New Brunswick, and the putting pen to  
6 paper on this letter in mid-December?

7 **A.** No, not ... you know, when we talk about  
8 stabilization, it's kind of getting that individual ready for  
9 more intensive therapy in that respect, and so there were  
10 concerns about the instability. Yeah, absolutely.

11 **Q.** And is it fair to say, in that seven-month period,  
12 were you able to even remotely get close to any sort of traction  
13 to engage in prolonged therap- ... prolonged ... I lost the ...  
14 prolonged exposure therapy ...

15 **A.** Exposure.

16 **Q.** ... prolonged exposure therapy that Dr. Rogers was  
17 able to engage with so frequently with Lionel Desmond?

18 **A.** No.

19 **Q.** Sorry?

20 **A.** Absolutely not. Absolutely not, you know, far away.

21 **Q.** So she seemed to be able to get there and was there.

22 What was preventing you from getting there in that seven months

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1 between May and mid-December?

2       **A.** Yeah, and you know what, I ... it's hard to really  
3 know, you know, what was different. Maybe the only thing that I  
4 really kind of wonder is, again, he was still kind of in that  
5 structured environment, right? He was still at work, he was  
6 still, you know, in the military, you know, and so I'm sure that  
7 was helpful. But now he's out. You know, as we discussed,  
8 there is this, you know, this increasing distress, you know,  
9 because he is out of the military. You know, the lack of  
10 purpose, the lack of meaning, right? And that is increasing his  
11 symptoms. He is isolated. He ... you know, so there is a  
12 number of factors. And so that just got in the way, right, in  
13 terms of ... and adding on to that, the substance abuse which we  
14 were worried about, it was interfering with the treatment  
15 process.

16       **Q.** And in terms of everyday stressors, he's back at home  
17 with his wife, it's not going well. Is that factoring into the  
18 mix of not being allowed or able to get that same traction that  
19 Dr. Rogers was perhaps able to get in the structured  
20 environment?

21       **A.** I think we can argue that. And let's add to that,  
22 being in Antigonish means that he's not physically here to

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1 attend an appointment. You know, an appointment over the phone  
2 is just, it's not as rich, right? It's difficult to get ...  
3 that non-verbal. It tends to be briefer. It's ... you know, so  
4 it's a challenge.

5 **Q.** So is it fair to say that prolonged exposure therapy  
6 can be successful with Lionel Desmond and his conditions?

7 **A.** Well, you know, I never got there, so it's ... I can't  
8 say that I was successful, you know, with that approach with  
9 Lionel Desmond.

10 **Q.** I guess I'll rephrase. So we heard from Dr. Rogers  
11 that prolonged exposure therapy was of great success for Lionel  
12 Desmond.

13 **A.** Yeah.

14 **Q.** He had actually been doing very well at one point,  
15 subject to bumps along the way.

16 **A.** Sure.

17 **Q.** So is any treatment, the success of any treatment, is  
18 it dependent upon its external environment and factors? I guess  
19 my question, I guess, is, you know, you want to apply that  
20 treatment in a community context versus in a structured  
21 environment.

22 **A.** Yes.

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1           **Q.** Is there challenges there? Is there a difference?

2           **A.** Yeah, I would agree to that, right? And, you know, to  
3 kind of elaborate, it's ... as you mentioned, there was a degree  
4 of success in, you know, with Dr. Rogers. You know, maybe the  
5 structure around Lionel at that time were helping with this, you  
6 know, treatment success, right? Whereas, you know, the  
7 environment that was around him, you know, when we were working  
8 with him, you know, there were stressors there, right? And it  
9 contributed to the dysfunction that we were observing. And so,  
10 you know, if, in September or October, right, we would've just  
11 kind of given it a shot, I don't know how successful we would've  
12 been, right? Just given, you know, these stressors around him.

13           **(14:20)**

14           **Q.** So the goals for admission as it relates to the Ste.  
15 Anne's recommendation, the first appears to be medication  
16 reassessment, is it?

17           **A.** Mm-hmm.

18           **Q.** And why was that important, from your perspective?

19           **A.** Dr. Njoku might be in a better position to answer  
20 that, but, you know, certainly, it is a ... you know, the  
21 medication is a big part of treatment, right? And so having  
22 another psychiatrist come and look at that, especially once the

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1 marijuana is no longer, you know, part of the equation, right?  
2 Are there changes, right? Are there changes in the  
3 presentation? And, you know, it had been a while at that point,  
4 I think, that the alcohol was no longer part of the equation,  
5 right? So it's at that state, at that juncture, you know, just  
6 kind of doing a bit of a reassessment and seeing if a change is  
7 appropriate or an increase or decrease.

8       **Q.** And the next, you were hopeful for improving coping  
9 skills. What were you looking for there to see Lionel Desmond  
10 get out of Ste. Anne's?

11       **A.** Yeah, so, you know, improving, adding. You know,  
12 right now, you know, as we were ... in the last few months, you  
13 know, there were instances where he's talking about using some  
14 of the skills learned in previous therapy, and the idea is can  
15 we add to that, right, in terms of the coping strategies to  
16 better handle the stress and the symptoms.

17       **Q.** Increasing structures in daily activities. What were  
18 you looking for there?

19       **A.** Well, we talked about, you know, the disorganization  
20 or the dysfunction when it comes to the day-to-day activities of  
21 daily life, right? And we were talking about, kind of, hygiene,  
22 we were talking about nutrition. And so, you know, can there be

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1 an improvement there for his structure.

2 Q. And finally, psychosocial rehabilitation was sort of  
3 the fourth goal of admission. What was that?

4 A. I know that with what they offer, they offer a lot of  
5 ... and I know we'll probably get to that. They have a lot of  
6 different professionals, right? You know, social worker and a  
7 lot of groups. So there is a group atmosphere, right? And  
8 seeing if we can get him into, you know, just, you know,  
9 tolerate that and see how well he does with other folks.

10 Q. And I'm just going to ask you a series of questions  
11 about the state of affairs at the time of December 15th when the  
12 recommendation is made December 15, 2015. So at the time of  
13 this recommendation, did Lionel Desmond, to your knowledge, have  
14 a family physician?

15 A. I don't believe so. Not to my knowledge.

16 Q. In your opinion, was he suicidal or homicidal?

17 A. I don't believe so. Not based on the note on that  
18 recommendation.

19 Q. Do you feel as though there was a risk for violence or  
20 aggression at the time of the referral?

21 A. No.

22 Q. How was his social network?

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1           **A.**    So it was limited. We had concerns there.

2           **Q.**    How was his motivation to engage in treatment?

3           **A.**    You know, up to that, you know, the last few weeks,  
4 you know, he seemed motivated.

5           **Q.**    Would you say that there was a significant number of  
6 identifiable external stressors in his life that could  
7 exacerbate his underlying PTSD and major depression?

8           **A.**    Yes.

9           **Q.**    And how was his relationship with Shanna Desmond?

10          **A.**    So as I've described there, you know, there were ups  
11 and downs. There had been, you know, situations, you know,  
12 with, you know, the incidents that we described earlier. A lot  
13 of financial. That stuff.

14          **Q.**    And finally in this recommendation, I'm going to read  
15 to you. You're thinking down the line and you note at the  
16 bottom, the last paragraph: "Telephone conference is  
17 recommended prior to discharge for collaboration of care, review  
18 of recommendations to ensure proper follow-up." What were you  
19 expecting to come out of that? What were you envisioning, upon  
20 the completion of Ste. Anne's, that was going to take place?

21          **A.**    Mm-hmm. And that's, I'd say, a pretty typical thing  
22 to request and, you know, when it comes to having that contact

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1 with the team. So it's just kind of getting a general summary  
2 there of how things went with the program.

3 Q. And I guess to go back, "But ultimately, all of this  
4 played into the key aspect of ..." I believe you said  
5 stabilization was the main goal in mind immediately.

6 A. Mm-hmm.

7 Q. Sorry, was that "yes" or "no?"

8 A. Yes.

9 Q. So if we skip ahead to page 65, now we're into January  
10 of 2016. It indicates that Mr. Desmond did not appear for an  
11 appointment. I understand that he advised you that he had  
12 attended a family funeral? Was that the case?

13 A. Right. It was at a later time, yes.

14 Q. Did he talk about ... and I believe he attended this  
15 funeral in Ontario. Did he talk about the impact that attending  
16 that funeral had on him?

17 A. Yes. He talked about, was it in the airplane that he  
18 had kind of issues with the airplane, if I recall here ...

19 Q. I guess it we look to page 63.

20 A. Mm-hmm. Oh wait. Yeah, so there was also, you know,  
21 a mention that he ... I think he did not go to the wake because  
22 it was ... because the deceased was exposed.

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1           **Q.**    So those sort of situations you understood were  
2 causing him some stress and anxiety?

3           **A.**    Yes.

4           **Q.**    Jumping ahead ...

5           **A.**    Given his PTSD and his ...

6           **Q.**    Yeah.

7           **A.**    Oh sorry.

8           **Q.**    Sorry, continue what you were going to say.

9           **A.**    Well, just given his PTSD and, you know, the traumas  
10 that were part of his experience, that wasn't a surprise.

11          **Q.**    And on January 25th, on page 62, you have a phone  
12 conversation with him and my understanding is that he indicates  
13 that he needed a little bit of time on his own since he and his  
14 wife had been arguing. He stated that she and their daughter is  
15 back in Nova Scotia. You offered support of listening.

16          So the purpose of this phone call, was a lot of it sort of  
17 about the stressors he was having within the relationship with  
18 Shanna?

19          **A.**    Yeah, I would agree with that. You know, I don't have  
20 anything really to elaborate, unfortunately, on the specifics.

21          **Q.**    February 5th, on page 61, you have noted again he had  
22 missed another appointment. According to my math, he's missed

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1 five appointments with you in an eight-month period. "He  
2 intends to be back and forth between Nova Scotia and New  
3 Brunswick." Do you have any concerns about that at this point?

4 **A.** Yeah, no, absolutely. It's, again, we're looking at  
5 interfering with, kind of like the treatment process and the  
6 engagement and the consistency, right and us being able to make  
7 some progress in moving forward.

8 **(14:30)**

9 **Q.** And I understand that he's getting close to attending  
10 Ste. Anne's but do you actually ...

11 **A.** True.

12 **Q.** ... have any conversation with Veterans Affairs,  
13 whether it's Ms. Doucette or even internally within the clinic,  
14 about the potential value in Lionel Desmond having your  
15 equivalent in Nova Scotia? So if he's in Nova Scotia he can't  
16 see you in New Brunswick, but he could see Dr. Murgatroyd in  
17 Nova Scotia. Is there ever any thought to this concept of maybe  
18 having two clinical psychologists in two provinces working in  
19 conjunction to facilitate this ease of access?

20 **A.** Yeah. I mean that's interesting. There ... when it  
21 comes to having two therapists it's a bit of a controversial  
22 area, right? Because of ... you know, sometimes there being

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1 inconsistencies in the modalities themselves, right? So let's  
2 say I'm seeing someone here and I find out that they're seeing  
3 somebody else from the community. You know, it might be, you  
4 know, a bit of a challenge to, you know ... in terms of our  
5 approaches aligning.

6 But it's an interesting thought when it comes to this  
7 situation specifically just because of, you know, the back-and-  
8 forth and at least having a person over there. I don't know  
9 that it was discussed.

10 Q. Okay, so that it can possibly create a number of  
11 challenges, you're saying, from a clinical perspective.

12 A. Absolutely. I think it is discouraged.

13 Q. It's discouraged?

14 A. Yes.

15 Q. What about having some sort of support, whether it's  
16 in a social work capacity or almost the role of a clinical care  
17 manager where they can assist him in, Hey, Lionel's, how's it  
18 going, don't forget you've got this appointment, you were  
19 looking forward to it, it's important, it's coming up. Is that  
20 resource ...

21 A. Mm-hmm.

22 Q. Is that something that could have supplemented you

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1 while you were in New Brunswick?

2 **A.** Absolutely, yeah. That sort of support and contact  
3 person, absolutely. That would have been appropriate.

4 **Q.** And taking it out of the hypothetical, was Lionel  
5 Desmond the type of client that needed that person?

6 **A.** Yes, I would agree with that.

7 **Q.** And we have this sort of notion that Lionel Desmond  
8 has sisters. Lionel Desmond has a wife. He has in-laws. He  
9 has friends. Can you see that being a little more less ideal  
10 than if it was an assigned professional worker to help him with  
11 that?

12 **A.** In ... what do you mean? Like in terms of getting  
13 that support from, I guess, a professional, kind of like an  
14 objective ...

15 **Q.** Yes.

16 **A.** ... individual or ...

17 **Q.** Yes.

18 **A.** Yes. Yeah. No, so absolutely, right? You know, and  
19 somebody with ... not to say ... I'm not sure if, you know, the  
20 family members had education when it comes to, you know, PTSD  
21 and all that but, you know, if that individual that would have  
22 been assigned had, you know, kind of like that experience, that

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1 background, that could have been really helpful.

2       **Q.** We heard a lot about Shanna Desmond had accompanied  
3 him to various medical appointments and, in fact, the ER, but no  
4 one would know about the relationship between the two and how it  
5 had its ups and downs and at times he wasn't there, would you  
6 say that, that was sort of a reliable ... an ideal person to  
7 rely upon, that she's going to make sure he gets all the help he  
8 needs?

9       **A.** I'm not sure I can answer that. I ... you know, I  
10 personally didn't have a whole lot of contact. I know that as  
11 we've been discussing today, there was that tension and kind of  
12 that ongoing tension. So I see what you mean, you know, that,  
13 you know, given that tension, her attending an appointment like  
14 that, you know, would it be beneficial? Yeah, I see what you  
15 mean. It's hard. It's hard to comment.

16       **Q.** Sure.

17       **A.** Regardless, having somebody else like ... that could  
18 attend an appointment with him could have been beneficial for  
19 sure.

20       **Q.** Okay, so we're going to go to April ... so page 54.  
21 We're now April 4th, 2016. Again, you have phone contact with  
22 Lionel Desmond. He indicated that the past week was

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1 distressing. What was going on in his life that was causing him  
2 distress?

3 **A.** It seemed as though the in-laws had returned. I  
4 believe they would go out West from time to time and that he had  
5 described that things at the household had been deteriorating.  
6 There was mention of sensitive or personal information had been  
7 shared and he was upset about that. And there is this mention  
8 of these divorce papers.

9 **Q.** So the concept of a divorce and papers. Is this again  
10 sort of the tensions rising again between him and his  
11 relationship with Shanna Desmond?

12 **A.** Certainly in this instance, yes.

13 **Q.** So we're closing the window sort of heading into the  
14 Ste. Anne's referral actually coming to fruition and does the  
15 ...

16 **A.** Yeah.

17 **Q.** ... relationship with Shanna Desmond appear to be  
18 improving or deteriorating based on what he's telling you?

19 **A.** Deteriorating, yes.

20 **Q.** And he makes a comment about, "He does not know if he  
21 will be able to commit to going to Ste. Anne's in May." There  
22 is some doubt there. What's going on? What's his concern?

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1           **A.**    Yeah, we were quite concerned, you know, as he was  
2 saying that, and I don't know. I'm trying to see exactly where  
3 I mentioned that. I don't know if it's just because of all the  
4 stress, because of the finances. I know that there's mention at  
5 some point that he's worried about being able to even make it to  
6 the airport.

7           **Q.**    And then you ...

8           **A.**    And the house is still up for sale. Mm-hmm.

9           **Q.**    And you indicate that you had planned to reach out to  
10 Ms. Doucette about the concerns?

11          **A.**    Mm-hmm.

12          **Q.**    I want to take you to a pre-clinic- ... critical  
13 session that you had with him at page 53. This is April 15th of  
14 2016. The session ... if you see there on the page it's titled  
15 "Stabilization". So at this session you're still at the  
16 stabilization phase?

17          **A.**    Yeah.

18          **Q.**    So have you yet to get to any sort of trauma treatment  
19 for his PTSD, any therapies as it relates ...

20          **A.**    No.

21          **Q.**    ... to PTSD or depression?

22          **A.**    No, not at all, and frankly, you know, it's ... we're

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1 barely doing stabilization work. We're meeting really  
2 inconsistently and it's mostly just kind of, you know, Where are  
3 things at now, right? Because, you know, let's say I haven't  
4 seen him in a month, right, due to the inconsistency. So just  
5 kind of catch ... playing catch-up a little bit, right? To be  
6 really honest, you know, a lot of the time it felt like I was  
7 more of a case manager than a therapist as we weren't really  
8 doing the work.

9 Q. So did it appear ... when you said at times it felt  
10 like you were sort of being a case manager as opposed to a ...

11 A. Mm-hmm.

12 (14:40)

13 Q. ... clinical psychologist, did it appear as though you  
14 were operating ... and you had Dr. Njoku as well. But did it  
15 appear as though it was the two of you and ... was there anyone  
16 else assisting in Lionel Desmond's multiple conglomerate of day-  
17 to-day issues in life?

18 A. We were the two, you know, clinicians, health  
19 professionals at the OSI working with him. We had Dr. Smith as  
20 well, not affiliated with the OSI.

21 Q. So I want ...

22 A. And of course ...



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1           You're familiar with that note that you made in your  
2 report?

3           **A.**    Yes.

4           **Q.**    From a clinical perspective as it relates to one  
5 stabilization, is this sort of reporting back to you of what  
6 he's experiencing significant?

7           **A.**    Yes. I mean it's ... you know, obviously he's  
8 stressed and this is causing him a lot of distress and he ...  
9 him being open about it is certainly a good thing.

10          **Q.**    This is probably a bit of a difficult question, but  
11 he's relaying this ...

12          **A.**    Sure.

13          **Q.**    ... in the context of he's having nightmares that his  
14 wife, Shanna, is cheating on him and then there's a violent  
15 context to the person she's cheating on him with and he talks  
16 about it being gruesome. But then he takes it ...

17          **A.**    Yes.

18          **Q.**    ... forward and takes it almost from sort of a dream  
19 context to he wonders if she is actually cheating on him. So  
20 ...

21          **A.**    Yes.

22          **Q.**    ... I guess you're the expert. Is his recurring

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1 nightmares and thoughts now invading his day-to-day beliefs?  
2 Because he seems to have drawn a parallel that maybe she is  
3 cheating on him.

4 **A.** Mm-hmm.

5 **Q.** Is one transferring kind of into the other?

6 **A.** I mean that's a fair point, absolutely, right? And so  
7 it's ... you know, he now has concerns, and also the reaction  
8 that she has was upsetting. You know, we know that with PTSD  
9 sometimes, you know, there are concerns with certain beliefs, as  
10 we kind of described earlier, with CPT. So he's ... you know,  
11 that might be part of it, right? And are we talking about  
12 delusion here? You know, I'm not sure, right? But it's ...

13 **Q.** At a minimum ...

14 **A.** It's certainly concerning, yeah.

15 **Q.** And at a minimum could you say that we're no longer  
16 just him reporting distressing dreams, he's now reporting  
17 distressing dreams and maybe distorted beliefs? His day to day.

18 **A.** That would be fair to say.

19 **Q.** And as well, this concept of he says he speaks to his  
20 wife about it. He speaks to Shanna about it and she laughed at  
21 him.

22 **A.** Mm-hmm.

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1           **Q.** Do you recall whether or not how he felt about her  
2 reaction to him saying, Look, I'm having these dreams and now  
3 I'm wondering if you're really cheating on me and you're  
4 laughing at me? Do you recall how he sort of was feeling about  
5 that? How he felt her reaction was to what his thoughts were?

6           **A.** Yeah. No, I don't remember anything specific other  
7 than what's noted down here but he was upset and ...

8           **Q.** He was upset that she did ...

9           **A.** He felt ...

10          **Q.** That she didn't give a ...

11          **A.** Felt unsupported.

12          **Q.** He felt unsupported.

13          **A.** And yeah, as I mentioned here, he was upset that he  
14 didn't receive a straight answer, yes.

15          **Q.** Do you remember what kind of straight answer he was  
16 looking for? What was he kind of looking for out of her when  
17 he's discussing this and his belief that she may be cheating on  
18 him?

19          **A.** My sense is that ... oh, sorry. My sense is that he's  
20 looking to know whether or not she's cheating on him.

21          **Q.** That he might be holding that belief that she's  
22 cheating.

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1           **A.**    That's my sense, yeah, based on the note, on the  
2 entry.

3           **Q.**    And did that seem distressing to him?

4           **A.**    He ... I mean he was distressed by the whole thing.  
5 So I imagine, yes. I don't have specific recollection.

6           **Q.**    And he takes it a step further. Right under it you  
7 note, "He is considering whether they should go ahead and get  
8 their divorce."

9           **A.**    Yes.

10          **Q.**    What was that in your understanding in the context of?  
11 Is he divorcing her because he believes that she may be cheating  
12 on him? Is he divorcing her because he's having these terrible  
13 thoughts? Or a collection of both? Did you get any sense of  
14 why he's now saying, Yeah, we should get a divorce?

15          **A.**    Well, I think we had talked about previously, you  
16 know, there had been mention, you know, prior to this note. So  
17 I don't know if it was in that context, right, that it's been  
18 discussed, yeah, we should go ahead and do that.

19          **Q.**    Okay, and clinically, are you able to ... you say that  
20 is a concern to you, but are you able to even begin to sort of  
21 help him get through that in any sort of treatment capacity?

22          **A.**    You know, again, it's trying to work through that

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1 moment. You know, the emotional regulation. You know, these  
2 are the types of things that we'd be doing in stabilization.  
3 I'm saying these things. I don't know if I was actually able to  
4 do these things, you know, given where we were at in treatment.

5 But you're listening to the individual. I see here an  
6 entry of ... suggesting that maybe he doesn't make any hasty  
7 decisions until he's been properly treated for his PTSD.

8 Q. Okay, and on the heels of this, April 15th, a week  
9 later there's another session at page 52 and he relays a number  
10 of concerns to you and I'll highlight them for you. He reports  
11 to you:

12 His partner has been sharing sensitive,  
13 personal information about him to his  
14 mother. He feels he cannot trust his  
15 partner. She has been holding onto divorce  
16 papers. He feels that she is being  
17 manipulative and is unwilling to work on the  
18 relationship, as he believes she needs to  
19 engage in her own therapy but won't. He  
20 froze their joint account. He may consider  
21 filing for bankruptcy and she's unwilling to  
22 talk to him over the phone.

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1           So again, is his focus ... I guess when I say these days,  
2 more on ...

3           **A.**    Mm-hmm.

4           **Q.**    ... the stressors of the relationship with her as  
5 opposed to reliving traumatic experiences that he experienced  
6 while he was in active duty? Is there a rise in the prominence  
7 of the home stressor compared to ... I know you can't separate  
8 the two, but is there a rise in the relationship stressors?

9           **A.**    At this particular moment I think we can argue that.

10          **Q.**    And is it at this session where he then requests that  
11 you rescind the consents to speak ...

12          **A.**    Yes.

13          **Q.**    ... with her?

14          **A.**    Yes.

15          **Q.**    Did you get a sense as to what it was, that why all of  
16 a sudden now he's saying he doesn't want you sharing information  
17 or gathering information from Shanna Desmond?

18          **A.**    Well, you know, I think it was secondary to everything  
19 that's going on, right? And the tension, right? So he wanted  
20 to exclude her, I suppose, from his treatment.

21          **(14:50)**

22          **Q.**    And how do you go about navigating this? It seems the

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1 tensions are sort of really at a boiling point, I'm going to  
2 say, and he's very ...

3 **A.** Mm-hmm.

4 **Q.** ... fixated on being hard done by her and he wants her  
5 pulled off of the consents, doesn't want you sharing information  
6 with her, doesn't want her sharing information with you. How  
7 are you treating that? How are you navigating that in that  
8 moment?

9 **A.** Look, to be honest, it's challenging, right? You  
10 know, we've got the rehab program that's coming up. You know,  
11 we're hoping to get him to that point to commit to it and not  
12 back out. You know, you're trying to get him to kind of focus  
13 on his healthcare and make sure that he is, you know, using the  
14 tools that he has, right? That might not be in here, but  
15 certainly, that's probably something that we're looking to do so  
16 that he can regulate.

17 Because he's ... as you mentioned, you use the word  
18 "fixated". That's what seems to have been going on at that  
19 point.

20 **Q.** And you finally say: "It may well be worth beginning  
21 to address his PTSD." What do you mean by "it may well be worth  
22 beginning to address his PTSD"? That's about five lines up from

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1 the bottom.

2       **A.** Yeah. At this stage I believe there had been delays  
3 in him being able to attend the Ste. Anne's program, and since,  
4 you know, the goal ultimately was to work on his PTSD and it  
5 seemed as though he was in the Fredericton area, Oromocto area  
6 due to this tension, that ... I guess that was the thinking,  
7 right? That maybe it's time to just go ahead and start doing  
8 this work. Because we don't know. We haven't gotten that  
9 confirmation, I don't think, at that point. So that was part of  
10 the line of thinking.

11       **Q.** Okay. And so if we move to May 3rd, 2016, page 51.  
12 So we're getting close to that Ste. Anne's ... we're in the same  
13 month of him attending Ste. Anne's. You have noted a telephone  
14 discussion that ... at 11 a.m. on May 3rd. He said that his ...  
15 him and ... he had communicated with his wife through text  
16 message and that it was not very constructive and it upset him.  
17 You said: "He indicated he called the VAC crisis line in order  
18 to talk to someone since it was after hours."

19       **A.** Mm-hmm.

20       **Q.** Do you know why he was contacting the VAC crisis line?  
21 What was it regarding? What crisis was he having?

22       **A.** So that crisis line is a resource that's available to

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1 veterans, and as is mentioned there, after-hours, right? So I'm  
2 assuming that it had been related to this ongoing conflict and  
3 the texts between he and his wife.

4 **Q.** Do you know ... did he discuss with you exactly what  
5 he ... what form of crisis he was in, what he thought was going  
6 to happen, why he needed to talk to someone in that moment?

7 **A.** Mm-hmm. It's ... my memory is not clear on that. I  
8 apologize.

9 **Q.** Sure, and you note below it, you said: "He is now  
10 realizing his best option is to probably go to Ste. Anne's  
11 sooner rather than later." Is it fair to say that he's sort of  
12 reaching a point of desperation, I guess?

13 **A.** I guess you could describe it that way, that he feels  
14 he really needs that service sooner rather than later as I  
15 indicated here. Yeah, and then especially with the stresses  
16 going on on an ongoing basis. Sure.

17 **Q.** In comparison to your time with him, up to this point  
18 would you ... is it fair to say he might be at his worst in  
19 terms of crisis in terms of life being in turmoil?

20 **A.** Yeah, I would agree with that. I think the next  
21 entry, you know, with Dr. Njoku, in collaboration with Dr. Njoku  
22 was, you know, probably the most agitated we had seen him. So I

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1 would agree to that.

2       **Q.** And so as well, on the same date, May 3rd, you had  
3 actually phoned Marie-Paule Doucette and you had indicated ...  
4 you had expressed to her that he was experiencing significant  
5 financial distress and wonders if VAC may be able to help him  
6 out. Could you tell us a little bit about that? What was that  
7 about?

8       **A.** Yeah, you know, that's a resource for a service that  
9 can sometimes be ... well, a few things. And if my memory is,  
10 you know ... if my recollection is good there, that they can  
11 have access to an emergency fund if deemed appropriate, and also  
12 potential financial counselling. So maybe those were the types  
13 of things that were discussed.

14       **Q.** If I could just have one moment. There is something  
15 that I just want to draw your attention to. It appears as  
16 though he reported to you ... if you look at that under  
17 "Telephone Discussion" at 11 a.m. The last line, it says: "Mr.  
18 Desmond is experiencing significant financial and said he would  
19 likely have to go to a food bank due to lack of funds." Do you  
20 recall that?

21       **A.** I don't recall that, you know, I'm seeing it here,  
22 right, so that would have been probably part of the conversation

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1 as well.

2 Q. So we'll never know, I guess, as to the full details  
3 as to why maybe his financial circumstances were as bad as they  
4 were, or the full extent to it, but from a clinical  
5 psychologist's perspective, if you have a client that is at his  
6 all-time worst in terms of trauma and external stressors and  
7 they're telling you, My financials are so bad that I have to go  
8 to a food bank, what kind of concern does that bring to you?

9 A. Well, as you mentioned there, he's kind of at an all-  
10 time low, right? He's not doing well. You know, we're looking  
11 at the different factors, right, risk factors, if you will. You  
12 know, that's why I'm on the phone and seeing if, you know,  
13 anything can be done, you know, to help out, you know, from a  
14 VAC standpoint, yeah.

15 Q. So do you find yourself in the uncomfortable position  
16 of not only being his clinical psychologist, what you had signed  
17 up for, and now you're performing the role as well of maybe  
18 community case manager?

19 A. I mean I ... hopefully I'm not coming across as, you  
20 know, saying that, you know, That's not part of the job. It  
21 sometimes it part of the job, right?

22 Q. That's fair.

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1           **A.**    To, you know, kind of, you know, make these referrals,  
2    make these suggestions.  So that's part of the job, right?  To  
3    have that contact, relay that information to the case manager.

4           **Q.**    Was there ever any discussion about how you can  
5    utilize someone to assist Lionel Desmond in those day-to-day ...  
6    because he's presenting to you with ... he needs to go to a food  
7    bank, and you're trying to navigate his post-traumatic stress  
8    disorder.  Was there ever any thought ...

9           **A.**    Sure.

10          **Q.**    ... to who this would be that would be able to assist  
11    him in those aspects to allow you to do your job?

12          **A.**    Yes.  Yeah, so ... and again, you know, with the  
13    benefit of hindsight, right?  A clinical care manager would have  
14    probably been appropriate at this stage.  Or let's be honest, at  
15    an earlier stage as we discussed previously.

16    **(15:00)**

17          **Q.**    And so you alluded to this.  Page 50, May 9th, there's  
18    a meeting where you pull in Dr. Njoku, so it's you, Dr. Njoku  
19    and Lionel Desmond.  And you had described him earlier as being  
20    probably the most agitated you had seen him.  I guess if you can  
21    give us a sense of how agitated he was and what was the source  
22    of main concerns at this time?  This is May 9th.

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1           **A.**    Yeah, it was still surrounding, you know, his wife and  
2 the finances, right? And we were trying our best to kind of  
3 bring him down and, you know, see if he can kind of notice that  
4 he's just kind of spinning, right, in that moment, and he's just  
5 fixated, right? So we're trying to ground him, basically, and,  
6 you know, kind of constructive brainstorming, right?

7           **Q.**    And when you say he's angered, he's agitated, is his  
8 voice elevated? Is he showing avert signs of sort of distress  
9 or very upset?

10          **A.**    Yeah, both. Yeah, both.

11          **Q.**    And you make a point of saying: "At times, it was  
12 difficult to redirect him as he kept circling back to his  
13 situation and how his wife cannot be trusted as she is ruining  
14 him financially." So was the crux of his agitation his wife and  
15 how he perceived that she was treating him?

16          **A.**    Yes. And, you know, and in terms of maybe her  
17 spending, yeah.

18          **Q.**    Did it appear as though his ... and I understand you  
19 weren't able to get to sort of the full sort of treatment of it  
20 or the underlying cause of the symptoms of PTSD he had and his  
21 depression, but did it appear as though his mental health crisis  
22 or difficulties seemed to sort of latch on to his wife as the

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1 source of most of his problems currently?

2       **A.** As we kind of talked about, touched on, there over the  
3 last few entries, you know, it seemed to be the main source of  
4 stress at that point, sure.

5       **Q.** You indicated that you tried to get him to focus on  
6 actions and problem solving rather obsessing and dwelling on  
7 problems. How did that go with him?

8       **A.** We were eventually able to, you know, kind of bring  
9 him down, kind of the grounding, as I kind of alluded to  
10 earlier. And he agreed to, you know, by the end there, to start  
11 a new medication there. So although, you know, a tense session  
12 ... well, I can only speak for myself, but it felt like it was  
13 constructive by the end.

14       **Q.** And you said, stating: "He changed his mind about Ste.  
15 Anne's and would like to go ASAP." So did he appear to sort of  
16 really indicate that he wanted to get there and get there now?

17       **A.** Yes.

18       **Q.** And why do you think that was?

19       **A.** Well, you know, again, with things kind of spiraling  
20 down in terms of the distress that he's experiencing, I'm  
21 assuming that he's looking for the help and maybe looking for  
22 that break, right?

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1           **Q.**    And we'll get more of this from Dr. Njoku, but did you  
2 get a sense that he was off medications at this point?  
3 Prescription medications? I note there's a note at the bottom  
4 about it. "Dr. Njoku able to convince him to start a new  
5 medication. Abilify, two milligrams."

6           **A.**    Yeah. Yeah, I'm not clear on whether he had anything  
7 else at that time but he did agree to start the Abilify.

8           **Q.**    And if we could turn to page 49, and this is at the  
9 bottom of the page, it's May 20th, 2016, 3 p.m. It says:  
10 "Phone contact with CM," which I'm assuming is case manager. So  
11 you received a call from Marie-Paule Doucette on this date, did  
12 you?

13          **A.**    Yes.

14          **Q.**    And what was the concern, I guess, Marie-Paule  
15 Doucette relayed to you? What was her purpose for reaching out  
16 to you on that date?

17          **A.**    Well, yeah, I think I alluded to this earlier, that,  
18 you know, she had met with him to just kind of go over the  
19 final, you know, details before his trip to Montreal. At this  
20 point, the admission date is set. And she'd met with him and he  
21 continued to be upset over the financial situation. There had  
22 been another argument with his wife, and Ms. Doucette seemed to

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1 be concerned that he might back out of attending the program.

2 Q. Did she say why she was concerned that he might back  
3 out?

4 A. Not that I can recall. You know, I wonder if it was  
5 just based on, you know, the level of distress that he, you know  
6 ... and, you know, he had voiced, you know, in the past that he  
7 was backing out there, so I just wonder if it was a combination  
8 of things.

9 Q. So I'm going to jump ahead. It appears as though,  
10 from the records, that that is pretty much the last contact you  
11 have with Lionel Desmond other than a brief phone contact with  
12 him on May 27th before he ends up at Ste. Anne's on May 30th.  
13 I'll take you to page 47. So you actually hear from Lionel  
14 Desmond when he's at Ste. Anne's. Is that correct?

15 A. Yes.

16 Q. And that's on June 14, 2016?

17 A. Yes.

18 Q. And who contacted who? Did you contact Lionel Desmond  
19 or did Lionel Desmond contact you?

20 A. It seemed like he left a voice mail on my phone.

21 Q. So I guess you must've had some sort of therapeutic  
22 alliance if he's thinking about calling you.

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1           **A.**    There you go, there you go. He didn't forget me.

2           **Q.**    He could've called a lot of people and he called you  
3 on that day. So you called him back and can you tell me a  
4 little bit about how he was finding the program in June?

5           **A.**    Yeah. Things seemed to be going pretty well, you  
6 know, based on my recollection and, you know, based on what he  
7 was describing. And, you know, I remember him kind of talking  
8 about, you know, them allowing me to go outside to bike around  
9 outdoors. He talked about the yoga that he was enjoying. I see  
10 there that he had changed medications or, you know, at least  
11 they had started him on the medications. And so that was the  
12 stabilization portion and that he was going to be starting the  
13 next phase of the residential program. And, you know, there's a  
14 nice little mention there that he wanted to make steps towards  
15 working on his relationship as maybe being a goal. And, you  
16 know, on that note, you know, he's kind of talking about  
17 allowing us to exchange information again, at least ... you  
18 know, I didn't do anything to that consent form, but at least we  
19 had it there, in my note.

20           **Q.**    So he had an interest in kind of bringing the consent  
21 back where you would share how he's doing with Shanna Desmond  
22 and you would speak to Shanna Desmond as to her views. Is that

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1 correct?

2 **A.** Yeah.

3 **(15:10)**

4 **Q.** So I want you to contrast for a moment just my  
5 interpretation of the notes. Between Lionel Desmond's phone  
6 call to you on June 14 of 2016 while he's at Ste. Anne's  
7 compared to May 9th, 2016, which is about a month prior when  
8 he's in at his worst, in with you and Dr. Njoku. Were these two  
9 very different presentations?

10 **A.** Yeah, quite dramatic, yeah, there was a change.

11 **Q.** And when you say "quite dramatic", I wonder if you can  
12 expand upon that.

13 **A.** Well, you know, it's kind of one end to the next,  
14 right? So, you know, and I guess we could ... it probably  
15 speaks to a few things but, you know, certainly, you know,  
16 having him in a structured environment, kind of taking him out  
17 of a stressful set of circumstances and providing intensive  
18 treatment, intensive care where he's taking care of himself  
19 seemed to be doing some good. And so that's certainly one, you  
20 know, observation, yeah.

21 **Q.** And I appreciate it's a phone call as opposed to a  
22 full in-office assessment.

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1           **A.**    Sure.

2           **Q.**    But if the goal, as you sort of sought when you first  
3 made the referral, was that key word of stabilization, did it  
4 seem like you were seeing signs of stabilization now finally  
5 when he's connected at Ste. Anne's?

6           **A.**    I would agree with that, yes. And, you know, I'm  
7 hearing him. He's telling me he's doing these things. It seems  
8 like he's maybe practicing them, yeah.

9           **Q.**    So would you say whatever is sort of happening in  
10 terms of his structure at Ste. Anne's appears to be working as  
11 you had hoped?

12          **A.**    Yeah, based on this entry, yeah, absolutely.

13          **Q.**    In your opinion, do you think, and knowing Lionel  
14 Desmond in the capacity you did, do you think he was the type of  
15 person that really - and given his conditions - benefitted from  
16 an organized structure, community support around him?

17          **A.**    Yeah. You know, based on what we ... based on what I  
18 know, right, and, you know, what I'm hearing, you know, from how  
19 well he was doing, you know, with Dr. Rogers and how well he did  
20 here versus, you know, how he was doing the rest of the time  
21 working with me, let's be honest. So I would say that that's a  
22 fair statement.

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1           **Q.**   And certainly, Doctor, I want to clarify, it's  
2 definitely not a critique of what you were doing. I want to put  
3 that on the record fairly. I mean you had the insight to make  
4 ...

5           **A.**   Sure.

6           **Q.**   ... the referral which, clearly, we had seen some  
7 positive results, you know. I'm just sort of curious about the  
8 different structures around him and supports around him in  
9 different contexts.

10          **A.**   Yes.

11          **Q.**   It's not really a question, Your Honour, but I thought  
12 it was fair to point that out.

13          **THE COURT:**    Yeah, you know what, I mean you can sit  
14 here, and we're all sitting here and we're all thinking about it  
15 and it would not be unusual for us all to have had a thought  
16 very similar to that, that, you know, going from the structure  
17 of the treatment in the CAF environment and then the same kind  
18 of ... and then he was released, and the same kind of structure  
19 that he sees in Ste. Anne's versus the lack of structure. And  
20 again, it's just an observation that that was the circumstances  
21 and not a reflection on anything that was made available through  
22 OSI NB, so I understand the purpose of your comment.

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1           **MR. RUSSELL:**    Oh thank you, Your Honour.

2           **THE COURT:**     Thank you.

3           **MR. RUSSELL:**    We're nearing the end, Doctor.  So page 46.  
4 June 29th, 2016, you receive a telephone call from a social  
5 worker, Kama Hamilton.  She's employed with the Ste. Anne's  
6 clinic.  What was her purpose for reaching out with you on this  
7 particular date?

8           **A.**     Yeah.  There had been an incident and she wanted to  
9 inform me about it, that there'd been an outburst during a  
10 meeting with a psychiatrist.  And she wanted to know if this has  
11 happened before, and that they had assessed his dangerousity  
12 level which was deemed to be low.  And other than that, it  
13 seemed like things were going relatively well and that they'd  
14 been in touch with his wife.  And there's an entry there that  
15 they might do some further psychological testing.

16          **Q.**     And so, Doctor, is this typically how things perhaps  
17 should operate ideally is that if he's being seen by one group  
18 of professionals, they contact the previous professional, they  
19 share and collaborate on information?  Is this, ideally, when we  
20 think about collaboration of care, how this is supposed to work?

21          **A.**     Yeah, this is a good example, sure.

22          **Q.**     And did you relay any sort of concerns to Ms. Hamilton

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1 when you had the discussion with her?

2       **A.** I'm not sure on that. It's possible that I would have  
3 told her that we had seen that before, you know, given the  
4 recent situation with Dr. Njoku, but I'm not sure on that.

5       **Q.** This concept of this word "dangerosity", is this a  
6 clinical term? I had never really seen it before until this  
7 record in the Quebec record.

8       **A.** Yeah, yeah, and I wonder if it's a translation of  
9 something like that from French, but, you know, probably  
10 assessing for his, you know, risk of violence and danger, yeah.

11       **Q.** So I want to take you to - there's a Ste. Anne's  
12 discharge conference, page 45.

13       **A.** Mm-hmm.

14       **Q.** So we know that Lionel Desmond was discharged from  
15 Ste. Anne's on August 15th or 16th. I might get that wrong. I  
16 believe it was August, either/or, I guess. We can operate on  
17 the principle that it was August 15th or 16th. The record  
18 reflects properly earlier on what the date was.

19       **A.** Mm-hmm.

20       **Q.** So we know he's discharged the middle of August. We  
21 know, when you made your referral, you were hopeful that there  
22 would be some sort of case conference that would discuss his

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1 transition when he left Quebec, coming back out and returning  
2 back to his home province or provinces.

3 **A.** Mm-hmm.

4 **Q.** Who was present for this telephone conference? It  
5 says "with team members from Ste. Anne's" and it talks about  
6 "external team". Do you recall who was on this conference?

7 **A.** Yeah. And unfortunately, no. And hopefully, you  
8 know, they might have that documented, but as I recall, I think  
9 it was maybe two or three or four individuals.

10 **Q.** So I guess, in fairness, they'll be able to recall who  
11 exactly from their end in Quebec was on there, but I'm thinking  
12 in terms of the external team. Were you present for this case  
13 conference?

14 **A.** Yes.

15 **Q.** Do you know if Dr. Njoku was?

16 **A.** No. It was by myself, yeah.

17 **Q.** And do you know if Veterans Affairs had anyone? Was  
18 Marie-Paule Doucette part of this conference?

19 **A.** I'm not sure. That I don't recall.

20 **Q.** I note ... So what is discussed at this case  
21 conference? One, what's the purpose of it, and then two, what  
22 is discussed?

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1           **A.** Well, it was to, you know, provide a summary of, you  
2 know, what went on, how Lionel did during the program, you know,  
3 go over some of their recommendations. And also, you know, they  
4 had a few short-term concerns that they wanted to discuss. So  
5 it's really the continuative care, right? It's relaying the  
6 information. Of course we're going to get the report which is  
7 more comprehensive, but this is a nice opportunity to kind of  
8 get a summary.

9           **Q.** And did you have the report the day of the case  
10 conference or no? I think we established that earlier.

11          **A.** No.

12          **Q.** You didn't receive the report with the recommendations  
13 until October 19th? Is that correct?

14          **(15:20)**

15          **A.** Sometime in October, maybe 7th ... October 7th.

16          **Q.** Okay. So the goal, I guess, is for Ste. Anne's to put  
17 recommendations in place that they recognize that Lionel Desmond  
18 requires for his mental health wellness. Is that correct?

19          **A.** Yeah, recommendations for kind of ongoing care.  
20 Absolutely, yeah.

21          **Q.** And when those recommendations are made by those  
22 professionals at Ste. Anne's, are they just sort of, Yeah, we'll

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1 consider them, or are they given significant weight, and say, In  
2 the sense that this group of professionals have had residential  
3 contact with him, the recommendations are meaningful and we  
4 ought to implement them. Is that correct?

5 **A.** Well, yeah, I would take them seriously. Of course,  
6 right, and I don't know if we've had the opportunity to talk  
7 about this yet, but this is going back to Veterans Affairs,  
8 right, and Veterans Affairs, you know, are the ones that kind of  
9 make the decisions, right, in terms of if a referral needs to be  
10 made, yeah. So ... but I was certainly interested in what they  
11 had to say.

12 **Q.** And so from your perspective, sort of, is it fair to  
13 say the default position is, you know, as a clinical  
14 psychologist, he's gone to a specialized program. If they're  
15 making recommendations, we ought to sort of listen and  
16 implement?

17 **A.** Yes, yes, absolutely, do our best, yeah.

18 **Q.** I note the report ... so you don't get that report  
19 right away. Is that typical that a veteran would get released  
20 from a program such as that and there would be a lag in the  
21 report of two months?

22 **A.** I'm not exactly sure how to answer that, you know,

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1 it's ... I think there's always going to be a bit of a delay.  
2 That's to be expected. You know, you've got a group of  
3 professionals that need to enter in their part, right, and it  
4 all needs to kind of go in together. They sign off on that and  
5 then it is sent over. So, you know, it's roughly two months, as  
6 you said. There's a delay that's to be expected and I don't  
7 know, it's hard for me to say, if that's typical, you know, the  
8 number of months, the number of weeks. You know, you've got  
9 summer in there. I don't know if that's a great excuse, but,  
10 you know, it's something. So sometimes vacations. And  
11 certainly we work with other partners, right?

12 I'm trying to remember but, you know, my recollection is  
13 kind of unclear on that. That's going to be a great question if  
14 you can ask Dr. Njoku because this would've been the first  
15 client that I would've dealt with Ste. Anne's, but I'm sure that  
16 he, you know, given, you know, his experience and his caseload,  
17 that he would probably have more clients go through their  
18 programs, but that would've been my first experience. I don't  
19 really have ... and I don't recall working with them after  
20 Lionel, so I don't have an example to kind of compare.

21 Q. So they conveyed there were going to be some detailed  
22 recommendations and we know the report, but you said in your

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1 notes there were a few short-term concerns. What were the few  
2 short-term concerns that had to be addressed and what was done  
3 to address them?

4       **A.** So they were worried about the traveling plans back to  
5 New Brunswick. And I imagine, I don't know, you know, if there  
6 was, you know, a conversation that's happening with VAC about  
7 that, right? And then the living conditions, I guess, you know,  
8 where he's going, right? You know, we're talking about an  
9 unusual set of circumstances, so, you know, if I may just kind  
10 of, you know, kind of touch on that, right? You've got a group  
11 over at Ste. Anne's who is receiving an individual who is, you  
12 know, has been part of a treatment team in New Brunswick and,  
13 you know, they've had contact with me, and then, you know, they  
14 find out that, no, he's not going back to his treatment team.  
15 He is, you know, relocating. So it's unusual, and so I imagine  
16 that that kind of came into play maybe when it came to their  
17 concerns, right, because he ... yeah.

18       **Q.** With that, was there any sort of discussion about the  
19 unusual nature? So all along, you make the referral, Lionel  
20 Desmond is with you, you're struggling because he's transient,  
21 and then he's out the door, and I understand he's out the door  
22 earlier than expected which was his choice.

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1           **A.**    Yes, yes.

2           **Q.**    Was there any discussion between you and Veterans  
3 Affairs as to, What are we going to do to navigate Lionel  
4 Desmond right out of the gate, because you don't want a similar  
5 problem of a lag of time where he's out bopping around the  
6 provinces without resources. Is there any discussion about  
7 that, the importance of having that connection right away?

8           **A.**    Yeah. You know, I see here in this entry, you know,  
9 and yes, maybe it should've been done a little bit sooner. I  
10 don't know if that's what you're asking. I see here that it's  
11 ... where did I see it. It seems like I was going to have that  
12 discussion with the CM to kind of start that process, kind of  
13 have that conversation.

14          **Q.**    And that's the final line in your report. It says:  
15 "The writer and his case manager to discuss plans to refer him  
16 to the OSIC in Halifax"?

17          **A.**    Yes. And that might suggest that she was maybe on the  
18 call but I'm not a hundred percent on that.

19          **Q.**    So your understanding, out of this case conference, to  
20 your knowledge, was there sort of a sound, common understanding  
21 as to where Lionel Desmond was going to reside permanently as of  
22 mid-August 2016?

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1           **A.**    Yes.  By that point, and I don't know that I have the  
2 specific date, but I think the house had been sold by that  
3 point.

4           **Q.**    You ...

5           **A.**    So it seemed like he was ... sorry?

6           **Q.**    Seemed like he was going to be where?  I might've  
7 missed that.

8           **THE COURT:**    He said he thinks the house was sold.

9           **A.**    It ... and so that he was relocating.

10          **MR. RUSSELL:**    Okay.  Also in this note from the case  
11 conferences there's a reference for a need of a  
12 neuropsychological assessment.  We've heard a little bit about  
13 what a neuropsychological assessment and I understand that  
14 that's fairly detailed, comprehensive, and expensive.  Does the  
15 OSI in New Brunswick offer that sort of assessment, a  
16 neuropsychological assessment?

17          **A.**    No, we don't have the proper assessment tools, nor the  
18 training.  I don't believe that we had anybody trained in ...

19          **Q.**    Off-hand ...

20          **A.**    ... that form of assessment.

21          **Q.**    Off-hand today, do you know if there's anyone in New  
22 Brunswick that offers those types of assessments?

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1           **A.**    You know, I think we have a few psychologists that  
2 specialize in that in Fredericton at the Stan Cassidy Centre.

3           **Q.**    And do you know why they were making a recommendation  
4 for a neuropsychological assessment?

5           **A.**    He had reported, or they had observed, either/or,  
6 concerns with memory and he had reported the head injuries which  
7 he had identified with us as well.

8           **Q.**    Did you see any sort of signs of cognitive limitations  
9 with Mr. Desmond, memory difficulties or things that could be  
10 consistent with perhaps a need of such an assessment in your  
11 experience with him?

12           **(15:30)**

13           **A.**    I think, if anything, he would've reported it. In  
14 terms of observing it, you know, as I mentioned, kind of jumping  
15 from one subject to the other. Like, sometimes we see that as  
16 part of PTSD. The challenge - and I don't know if it's okay if  
17 I just add this - the challenge is, when we were seeing him, is  
18 that the stabilization is not ... we haven't gotten there,  
19 right? So it's really difficult, you know, at that juncture to  
20 really, you know, tease apart what's actually going on, right?  
21 In the early stages, he is abusing alcohol. Well, we know that  
22 with alcohol use, that has an impact on cognitive abilities, not

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1 to mention the PTSD and the major depressive disorder. And then  
2 as he is making improvements with the alcohol use, he is now,  
3 you know, using marijuana regularly. So ... and we know that,  
4 you know, research suggests that that can also have an impact on  
5 cognitive abilities. So it's really difficult to tease apart,  
6 so that's where the stabilization is so important, right, in  
7 order to kind of have, you know, a better sense as to what's  
8 going on here, including, you know, potentially, you know,  
9 something like a head injury.

10 So although it's maybe not mentioned in, you know, the  
11 notes, right, you know, part of getting him stabilized and part  
12 of the goal of getting him to Ste. Anne's is kind of getting him  
13 to a state where, you know, he's kind of "clean", you know, not  
14 abusing any substances, so that they're able to kind of see,  
15 Okay, this is Lionel Desmond, right? And, you know, What's kind  
16 of going on here in terms of the presentation and what might  
17 that be related to? So ... if that makes sense.

18 Q. And we know that he left the program early. Exactly  
19 how early, I guess it's fair to say it's unknown, but during  
20 this case conference, did you or anyone else express a concern  
21 that he was leaving early? We know that he left early because  
22 he said he wanted to be back and spend some time with his

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1 daughter before she started school, but were there any concerns  
2 expressed either by you or anyone, that you recall from, as part  
3 of this case conference, about, Oh-oh, he's leaving early. We  
4 wish he had have stayed for the duration. Was there any  
5 indication of that?

6 **A.** They alluded to, you know, it being against their  
7 medical advice, and so there were concerns conveyed that way, to  
8 my recollection. How many weeks were left, I'm not exactly  
9 sure. They'll be able to speak to that.

10 **Q.** And we know what got shared with you from Ste. Anne's.  
11 It was the 11-page interdisciplinary discharge report. Did they  
12 ever share all the detailed case notes from the clinical care  
13 manager or his clinical case ... I'm getting all the terms mixed  
14 up myself ... the psychologist, Dr. Gagnon; social worker, Kama  
15 Hamilton, did you get detailed reports from them at any point?

16 **A.** No. Other than what was received in that document  
17 that you have there, we didn't receive anything else.

18 **Q.** So I'm going to ask you now about the concept of, you  
19 have an indication he's going back to Nova Scotia, and the  
20 importance of maybe referring him to Nova Scotia. And if we can  
21 turn to page 94. And we'll hear more from representatives out  
22 of Nova Scotia but we do know, in 2015, at various stages, there

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1 actually wasn't an OSI clinic and that explains why you, in New  
2 Brunswick, had a satellite office in Nova Scotia.

3 **A.** Sure.

4 **Q.** But on page 94, this is an inter-clinic referral form.  
5 It seems to be a referral date of September 30th. Referral  
6 source is you, so I understand that you made this referral?

7 **A.** Yes.

8 **Q.** And the referral was to the OSI clinic which was newly  
9 established in Nova Scotia?

10 **A.** Yes.

11 **Q.** And who would you have had to send this referral to?  
12 Do you send it directly to Nova Scotia or do you send it to  
13 Veterans Affairs?

14 **A.** I send it directly to the clinic.

15 **Q.** Okay. And did you copy Ms. Doucette on that referral?

16 **A.** I don't believe so.

17 **Q.** And did you have some discussions with Ms. Doucette  
18 leading up September 30th? Between the case conference with  
19 Quebec and September 30th referral to OSI Nova Scotia, did you  
20 have some discussions with Ms. Doucette as to the importance of  
21 making this referral?

22 **A.** I'm not seeing an entry here, so I certainly don't

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1 want to, you know, guess, but certainly, in the past, we talked  
2 about our eventually doing this.

3 Q. So to your sort of recollection and understanding, did  
4 Veterans Affairs know that you were making the referral to the  
5 OSI Nova Scotia about a month after his discharge from Quebec?

6 A. I think it had been discussed, yes.

7 Q. And my question is why did you make this referral, I  
8 would say, so soon? It's within a month of him being discharged  
9 from Quebec and you make this referral within a month. Why the  
10 quick reaction or quick action on your part to make this  
11 referral?

12 A. Sometimes I kind of wonder, just kind of reviewing it,  
13 you know, rereading the file, if it could've been sooner. It's  
14 kind of one of those things where I was ... we were waiting for  
15 the reports and we were hoping to have them, right, so that the  
16 folks in Halifax would kind of have that in front of them as  
17 they're meeting with Lionel, right? So ultimately, I said, you  
18 know, it is time, right? You know, we can't wait any longer. I  
19 realize that I had had phone contacts with Lionel and I  
20 encouraged him to reach out if he needed, but he was now over in  
21 Nova Scotia, you know, he was no longer a New Brunswick  
22 resident, right? So it was time to make that transition or that

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1 inter-clinic referral.

2 Q. And when you made the referral on September 30th, did  
3 Lionel Desmond have knowledge that you were going to refer him  
4 to the Nova Scotia OSI clinic?

5 A. Yes.

6 Q. And I guess I want to know your rationale for the  
7 referral. Why are you referring him to the OSI Nova Scotia as  
8 opposed to Tom Smith, clinical practitioner, in Antigonish? Why  
9 are you sending him to OSI Nova Scotia and not a practitioner in  
10 Antigonish?

11 A. You know, the OSI has that expertise, right? That's  
12 what they do. They work with veterans, they work with, you  
13 know, individuals who have an OSI, right, or struggling with the  
14 OSI, so, you know. And they have that collaborative approach  
15 and they're able to, you know, consult amongst each other. So  
16 they are equipped to do that work with veterans. And also, you  
17 know, I think, in terms of prioritizing a case that's already  
18 opened, I believe, you know, I'm trying to remember if that was  
19 usually a priority versus somebody ... I think that's how we  
20 operated whenever we received somebody, let's say from Ontario,  
21 that there might be a priority, just given that it's a transfer  
22 versus a new referral. Hopefully, I'm right on that one.

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1 That's how we do it here.

2 So, you know, given all of these reasons, it was a "no  
3 brainer" to send them over there to kind of get that  
4 continuative care.

5 **Q.** Was Lionel Desmond, in your discussions with him about  
6 the referral, was he on board and supportive of the OSI clinic?  
7 It's in Halifax and that's probably the best spot for me? Did  
8 he have to "buy in" at that point?

9 **A.** Yeah, I'm seeing here that he consented to this. You  
10 know, my memory is not clear on it exactly at that specific  
11 moment. I know that in the past, there had been concerns just  
12 because Halifax is a larger centre, but I don't recall any  
13 concerns expressed at that time ...

14 **(15:40)**

15 **Q.** I'm going to ask you sort of a ...

16 **A.** ... when I sent the referral.

17 **Q.** And it's going to come down to how this referral sort  
18 of maybe never happens, but I'm going to ask you a question in  
19 terms of, we've heard a discussion about the autonomy of a  
20 patient and their right to sort of choose what they want for  
21 their care. So anyone can leave any program at any time subject  
22 to special limitations under various **Acts** and the importance of

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1 that, the integrity of the person. But is the role of a  
2 clinical psychologist or a healthcare professional to provide  
3 expert informed guidance for a patient? And what I'm asking is  
4 if you see a patient that may be making a decision that's  
5 contrary to maybe rationally what is probably in their best  
6 interest, is it your role to sort of encourage them and guide  
7 them to sort of understand perhaps why they should be turning  
8 their focus back? Does that make any sense?

9 **A.** Yeah, I think I'm following. Are you referring to his  
10 decisions ultimately?

11 **Q.** Yeah, for exam- ...

12 **A.** Yeah.

13 **Q.** Yes, for example, Lionel Desmond. If he's going to  
14 make a decision that's probably contrary to his best interest,  
15 is it your role as a healthcare professional, not to tell him  
16 what to do, but to help him understand why one decision might be  
17 better for him than, say, the other?

18 **A.** Mm-hmm. Yeah, it's certainly case-by-case and, as you  
19 said there, you know, depending on the person that you're, you  
20 know, speaking to, right? And you want, you know, there to be a  
21 certain level of autonomy, a certain level of, you know,  
22 respecting the individual and their choices and their decisions,

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1 right? But there's also the flip side, right, of us kind of  
2 knowing that the expertise is there and, you know, kind of  
3 conveying that message.

4 So certainly, you know, that's something that could have  
5 been looked at and I don't know if that was part of this  
6 discussion. It's not in the entry during our final  
7 conversations.

8 Q. For example, there was various points where Lionel  
9 Desmond had, sort of in the moment, said, I want to push off  
10 going to Ste. Anne's because my finances aren't perfect. Or, I  
11 want to spend more time trying to work on my relationship. And  
12 you were able to discuss with him probably the importance of  
13 going to Ste. Anne's. Is that correct?

14 A. Yeah, that would be a good example, sure.

15 Q. And so if you had sort of ... and I recognize that you  
16 weren't there for the final decision that Lionel Desmond  
17 ultimately made, and we may not know what all factored into that  
18 decision, but if you were meeting with Lionel Desmond and he  
19 decided, I don't want to go to the OSI clinic in Halifax because  
20 it's too far away from Guysborough, it's too far away from  
21 Antigonish, would you have had a discussion with him that  
22 might've encouraged him to maybe reconsider? I know it's a

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1 little abstract, but just built on the relationship you had with  
2 him, knowing what you knew was in his best interest, would you  
3 have had that sort of conversation had you had the opportunity?

4 **A.** And especially because I believe what we were  
5 recommending, especially the psychiatric follow-up at the  
6 hospital and then having an appropriate therapist in the  
7 community where the travel wouldn't be as frequent, right? I  
8 probably would've had that conversation with him that, you know,  
9 having that connection to OSI, you know, a psychiatrist that,  
10 you know, has a lot of experience, you know, working with the  
11 military, it is in your best interest. You know, talking about  
12 having to go down there not as frequently, you know, as would be  
13 the case with a therapist, right? So I could see myself having  
14 that sort of discussion with him.

15 **Q.** And you understood that the referral was going to be  
16 to the Nova Scotia OSI for both therapy, psychiatry ... It was  
17 going to be, again, another sort of in-house treatment  
18 structure. Is that sort of your initial understanding of what  
19 this was going to be? It was going to be sort of an all-  
20 referral?

21 **A.** Of course, on their end they kind of certainly do  
22 their own ... there's probably an intake, an assessment, you

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1 know, that they're doing, so they can go based on what I'm  
2 suggesting, or, you know, kind of based on their assessment, but  
3 I'm seeing here that the recommendation was ideally finding  
4 somebody in the community that had hopefully an appropriate  
5 background, you know, working with the military - I know that  
6 there's a university not too far away - you know, to maybe avoid  
7 this back and forth. You know, he wanted to remain in that  
8 area, right? So I'm seeing here that I've made the suggestion  
9 to, the recommendation to, have the psychiatric follow-up and  
10 ideally, a therapist in his community.

11 **Q.** And when you were contemplating a therapist in his  
12 community, did you have a particular skillset of therapists in  
13 mind? Not saying that one therapist is necessarily better than  
14 others, much like I wouldn't say that one lawyer is better than  
15 others, but you certainly wouldn't want to come to me if you  
16 needed a divorce. I don't have that skillset.

17 **A.** Mm-hmm.

18 **Q.** So is it much like that, when you go to a clinical  
19 psychologist or therapist, that you were thinking a particular  
20 skillset would be best suited for Lionel Desmond? Did that  
21 cross your mind?

22 **A.** Yeah, you know, so somebody with the proper training,

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1 you know, the proper experience, right, in, you know, having  
2 dealt with PTSD, having dealt with military, right? So that's  
3 what I would have in mind.

4 Q. And did you sort of just assume that that would've  
5 been evaluated and taken into consideration by the ultimate  
6 decision-maker that's working with Lionel Desmond, to have that?

7 A. Like Veterans Affairs? Yeah, sure.

8 Q. So I'm going to take you to page 42 which is October  
9 18 of 2016, and you have a phone conversation with a nurse at  
10 the OSI clinic in Halifax and noted by the name of Natasha.  
11 We've since learned that it's Natasha Tofflemire. What was the  
12 purpose of that contact initiated by you on that date and what  
13 did it involve?

14 A. I wanted to just kind of follow-up, right, to see, you  
15 know, where, you know, what happened, you know, if, you know, on  
16 their end, you know, if they followed up with Lionel, and so  
17 kind of get some information, you know, because we were kind of,  
18 on our end, we were going to close the file, right? So I just  
19 wanted to make sure that things were kind of set up over there.  
20 And, you know, based on the note here, it seemed like there was  
21 a contact, right, and that she ... I was informed that,  
22 ultimately, he was going to have a therapist in the community

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1 and that he would be also looking to set up psychiatric services  
2 in the community. And I was informed - I'm seeing it here, I  
3 don't recall - that for the time being, Marie-Paule Doucette  
4 would remain his VAC CM. And I don't know if that's just a  
5 question of, you know, wanting to make sure that he has someone  
6 until somebody can pick him up in Nova Scotia. And so I then  
7 left a message on Marie-Paule Doucette's phone, voicemail, to  
8 kind of confirm the above and kind of what I had just been  
9 informed of. She was out of the office and so I left a message  
10 ...

11 Q. So I just want to ...

12 A. ... and ... yeah.

13 Q. ... back up a little bit there, Doctor, if I can.

14 A. Mm-hmm.

15 Q. So when you were making these notes - and I know  
16 you're basing a lot of your recollection off of the notes - how  
17 soon after, you know, in your state of practice, were you making  
18 notes into the system compared to when the events happened? So  
19 in the phone call, you have a note it happens at 9 a.m. As a  
20 rule, how soon after are you making your notes into the system?

21 **(15:50)**

22 A. Hmm. You're going to get me in trouble. You know, as

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1 soon as possible, ideally, right? You know, sometimes there may  
2 be some delays, right, and you get to those notes at a later  
3 time in that week. In this particular case, I don't recall.

4 Q. Okay.

5 A. Usually, when there's a series of notes, you know,  
6 usually, I'd be doing them shortly after, given that there are  
7 several steps, right?

8 Q. Okay. So I just want to talk first about the first  
9 one and that's the phone call with nurse, Natasha Tofflemire.  
10 You note that: "The writer spoke with OSI nurse Natasha who  
11 confirmed she contacted Mr. Desmond to complete a triage. She  
12 indicated, at this time Mr. Desmond has a therapist in the  
13 community and that he would also be connected for psychiatric  
14 services in the community."

15 So I take it from your note that you're reporting that the  
16 nurse, Natasha Tofflemire, had indicated to you that she had  
17 completed a triage with Lionel Desmond?

18 A. Yeah, that was my understanding.

19 Q. And you noted as well that she had told you  
20 specifically and directly that he actually has a therapist in  
21 the community as of October 18, 2016?

22 A. Yeah, that was my understanding.

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1           **Q.** Was there any discussion about who this therapist was  
2 or where at in Nova Scotia?

3           **A.** No. Otherwise, I imagine I might've identified the  
4 therapist in the note, but I don't have any recollection, no.

5           **Q.** Was there any discussion as to who he was going to be  
6 connected in the community for psychiatric services? Was there  
7 any discussion as to entity, which doctor?

8           **A.** No, not to my recollection.

9           **Q.** But you were on the understanding that your referral,  
10 as it was, which was psychiatric services, OSI, and therapist in  
11 the community, has now changed. Is that my understanding?

12          **A.** Yes.

13          **Q.** And is this the first time you're informed that your  
14 referral, as it was, to involve the OSI clinic in Halifax, is  
15 this the first time you were told, Well, no, it's not going to  
16 involve OSI Halifax?

17          **A.** Yes.

18          **Q.** Did you pursue the decision any further? It shows  
19 that you tried to reach out to Marie-Paul Doucette before  
20 closing the file. Were you trying to reach out to her to get  
21 some explanation or understanding as to why the decision was  
22 made and how it came to be that - you know, you're a treating

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1 clinical psychologist, you made a recommendation to what you  
2 thought was best suited - why that suddenly changed or what went  
3 into the process of changing?

4 **A.** Again, that might've been part of what I was looking  
5 to convey. I don't know specifically. You know, it was a voice  
6 message, right? I think, as indicated in the note, I think I  
7 was just relaying the information. I hear what you're saying  
8 there and I still think the recommendation was a good one, a  
9 valid one, but based on what I was hearing, I was still ...  
10 what's the word? I was glad to hear that, you know, services  
11 were being put in place.

12 **Q.** And did you ... you've been very diligent in  
13 documenting your notes and I didn't see any other document or  
14 entry that said you had actually spoken to Ms. Doucette. Did  
15 you ever speak to her about this after being provided that  
16 information?

17 **A.** Not to my knowledge and, yeah, that was a bit  
18 surprising.

19 **Q.** And that's at 9:30, so the first call is 9 a.m. 9:30  
20 is the call, message to Doucette, and 10 a.m., you have a brief  
21 telephone chat, as indicated, with Mr. Desmond. What did you  
22 talk to Lionel Desmond about that morning?

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1           **A.**    So I wanted to kind of close the loop on, you know,  
2    kind of getting his take on kind of what had happened there, and  
3    also kind of get a sense as to how he was doing in general. And  
4    although it's not indicated in there, I'm sure, you know, I  
5    would've had a discussion there of, you know, that the file  
6    would be closed, you know, here in Fredericton. So those were,  
7    you know, the main things that we were discussing during this  
8    conversation.

9           **Q.**    And you note that, and I'll read it back: "Mr.  
10   Desmond confirmed that the OSIC in Halifax contacted him and  
11   that at this time, he would prefer accessing community resources  
12   than have to travel to Halifax." So the way you noted that  
13   there, was it your understanding that Lionel Desmond was  
14   speaking to somebody from the OSI in Halifax?

15          **A.**    Yeah, that's my understanding.

16          **Q.**    And he indicated that, personally, he would prefer  
17   accessing community resources. So did you have any discussion  
18   with him as to why you felt it was important maybe for him to  
19   give Halifax a try, or the OSI clinic in Halifax an opportunity,  
20   even though there were the geographical barriers?

21          **A.**    Mm-hmm. Yeah, and I don't recall if I went there.

22          **Q.**    What is interesting and I want to ask you about is you

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1 noted in your report: "He does not yet have a local therapist,  
2 but this will be discussed with his CM (case manager) once she  
3 gets back from her vacation."

4 So at 9:00, you indicate that Natasha Tofflemire tells you  
5 that he does have a therapist in the community, and then at  
6 10:00, you indicate that Lionel Desmond, in fact, tells you  
7 specifically he doesn't. Do you recall whether you wrestled  
8 with that sort of divergent sort of, did he have a therapist or  
9 didn't he have a therapist?

10 **A.** Mm-hmm. Yeah, and kind of rereading it as well,  
11 right, you know, I see that that is a discrepancy.

12 **Q.** Do you recall anything about that? Whether you were  
13 curious as to, in fact, whether there was or there wasn't a  
14 therapist set up for him or at what stage the therapy was?

15 **A.** Yeah. I took what he said at face value, and kind of  
16 wondering if I'd misheard there on the first call, so ... but  
17 with my, you know, again having left a message with Marie-Paule  
18 Doucette and he's telling me that they're going to be kind of  
19 having that discussion and kind of setting that in place, I felt  
20 pretty good about that. And it seemed, based on our  
21 conversation, as though he was doing relatively well.

22 **Q.** So I guess I could take from your sequence of

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1 conversations that morning is that as of October 18, 2016, you  
2 were comfortable in the idea that there was going to be a  
3 structure of some level to someone's satisfaction that something  
4 was going to happen in Nova Scotia. Is that correct?

5 **A.** Yes.

6 **Q.** And is that sort of the very end of the sort of  
7 activity on the file for you? Is that the last time you speak  
8 to Lionel Desmond?

9 **A.** Yes.

10 **Q.** And I'm going to ask you about page three. Just we're  
11 going to conclude here with page three. I'm going to read this  
12 into the record, bring it up on the screen. December 22nd,  
13 2016. Do you recognize this document?

14 **A.** Yes.

15 **Q.** And this is a letter that you addressed to Ms.  
16 Doucette, the VAC case manager.

17 **A.** Yes.

18 **Q.** This letter is to follow up to our last  
19 telephone conversation regarding Mr. Lionel  
20 Desmond. As discussed, Mr. Desmond is now  
21 permanently living in Nova Scotia and it is  
22 my understanding that he is connected with a

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1 local mental health team, therefore, his  
2 file at the OSI clinic will be closed at  
3 this time. Thank you for referring Mr.  
4 Desmond at the OSI clinic and please do not  
5 hesitate to contact the undersigned if you  
6 have any questions.

7 **(16:00)**

8 Do you recall writing that letter and sending it off to Ms.  
9 Doucette?

10 **A.** Yes.

11 **Q.** So there's going to be a few things I want to ask you  
12 about the letter, is it refers to "a follow-up to our last  
13 telephone conversation". So it seems to appear as though you  
14 might have spoken to Ms. Doucette on the phone?

15 **A.** Yeah. You know, so I noticed that as well, right, and  
16 unfortunately I'm not seeing that entry.

17 **Q.** And it then ...

18 **A.** And I don't know ... oh sorry. I don't know if here I  
19 was referring to the case conference, right, so that seems like  
20 that would have been kind of far away for us not to have a  
21 conversation. But yeah, sorry, I don't have anything other than  
22 that.

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1           **Q.**    And you said, "Mr. Desmond is now permanently living  
2 in Nova Scotia." So it was your understanding that Ms. Doucette  
3 was on the same page as you, that Lionel Desmond is now in Nova  
4 Scotia permanently. Is that a fair interpretation?

5           **A.**    Yes.

6           **Q.**    "And it is my understanding that he is connected with  
7 a local mental health team." So in your letter you say "mental  
8 health team - a local mental health team," you don't reference  
9 just a therapist. I don't mean to sort of over-analyze your  
10 words but did you understand that there was going to be some  
11 sort of team structure put in place in Nova Scotia for Lionel  
12 Desmond?

13          **A.**    Yeah. You know, maybe I was probably referring to  
14 psychiatry and therapy. The mental health team was a stretch in  
15 just kind of like the way I worded it.

16          **Q.**    But did your understanding, when you authored that  
17 letter closing the file, is that Lionel Desmond's treatment  
18 structure in Nova Scotia would have involved more than one  
19 community therapist?

20          **A.**    Yeah, with also a psychiatrist there.

21          **Q.**    And if I told you that his psychiatry support was  
22 whatever psychiatrist was in a random ER depending on which area

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1 in Nova Scotia he was, is that what you would have contemplated  
2 for psychiatric follow-up?

3 **A.** Well, you know, when we made that decision to, you  
4 know, to not go with the OSI team in Halifax, right, I was not  
5 familiar with, you know, who is necessarily practising in  
6 Antigonish, not to say that, you know, it wouldn't be  
7 appropriate. So, of course, when I sent the referral what I had  
8 envisioned was, you know, a psychiatrist, you know, who had  
9 experience working with military veterans and PTSD.

10 **Q.** And did you contemplate a psychiatrist that was going  
11 to sort of take an assignment of Lionel Desmond on as a patient  
12 and he was going to sort of navigate through each step of the  
13 way with Lionel Desmond? Is that what you contemplated when you  
14 talked about ...

15 **A.** Yes.

16 **Q.** Yes. So, quite different than well, psychiatric  
17 follow-up involves whatever psychiatrist you see in a random ER  
18 when you're in a state of crisis. That's not what you had in  
19 mind?

20 **A.** No.

21 **Q.** And why is maybe one ... from your standpoint and  
22 understanding, why was your expectation, I guess, better and

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1 more appropriate for Lionel Desmond than just leave him to  
2 random psychiatrists in the ER?

3       **A.** Well, again, the continuity of care, I know we've  
4 touched on that for a few times today and the ... not that a  
5 case manager, you know, at Veterans Affairs wouldn't be able to  
6 maybe relay, you know, some of the file, you know, be able to  
7 kind of find, you know, the psychiatrist.

8       But if it's moving from one psychiatrist to the next,  
9 right, it's maybe difficult for them to access, you know, the  
10 ... you know, the file in New Brunswick and the file in Quebec,  
11 right.

12       But, you know, if everything is happening in, you know, at  
13 the OSI Halifax, or at the very least the psychiatric follow-up,  
14 you know, the ... I guess the team approach with Veterans  
15 Affairs it's much more easier to relay that information because  
16 they should have access to that record from Montreal. They  
17 should have ... it should be easier for them to access  
18 information from the OSI in Fredericton. You know, if I'd sent  
19 the information from Dr. Njoku, if they need a little bit more  
20 information they ... you know, they get ahold of us, they know  
21 how to find us, right, so ...

22       **Q.** And ...

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1           **A.**   ... the ... yeah.

2           **Q.**   And I'm going to conclude with that. You had  
3 indicated, "Do not hesitate to contact the undersigned if you  
4 have any questions."

5           So clearly we know Lionel Desmond, he moves on in a  
6 different capacity with ...

7           **A.**   Yes.

8           **Q.**   ... different professionals. Your OSI clinic running  
9 notes, Dr. Njoku's running notes, the details of all of the  
10 trauma and the crisis he was experiencing, how it was  
11 documented, did anyone from Veterans Affairs or any other  
12 provincial agency, to your knowledge, ever come looking to see  
13 what information you or Dr. Njoku had documented?

14          **A.**   Not to my knowledge. I'm not sure.

15          **Q.**   If you were a clinical professional receiving Lionel  
16 Desmond as a client after October of 2016, would you have liked  
17 to have known what was in the New Brunswick file?

18          **A.**   Yeah, to, you know, kind of provide that context,  
19 right, and that background. At the very least, the psychiatric  
20 file, the psychiatric notes.

21          **Q.**   And to your knowledge it remained in New Brunswick; it  
22 never went anywhere?

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1           **A.**    To my knowledge.  And other than, you know, of course,  
2 I sent the ... Dr. Njoku's notes to the OSI in Halifax.

3           **Q.**    Yes, okay.  Thank you, Doctor, I don't have any  
4 further questions.  I know some of the questions were probably  
5 no doubt difficult and I thank you so much for everything you've  
6 done to assist Judge Zimmer and the Inquiry, and thank you.

7           **A.**    Thank you.

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

9           So we have hit our own crossroad here.  It's 10 after 4 and  
10 we would normally break at 4:30 and we started at 1:15.  We can  
11 ... I don't know how many questions counsel might have for Dr.  
12 Murgatroyd but I suspect that there may be a few.

13           So we can either take a break and look at continuing today,  
14 and of course that is ... takes into account, right, I would  
15 have to ask whether or not Dr. Murgatroyd and Mr. Canty were  
16 available to continue today.  The alternative is that we would  
17 simply have to find another convenient time to come back for  
18 cross-examination or questions, if I can put it that way.

19           So let me start with ... because I know that everybody  
20 that's here is not ... hopefully not travelling far, they're  
21 staying locally and will be here tomorrow again I think.

22           So, Dr. Murgatroyd and Mr. Canty, what does your

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1 availability for ... if we were to take a short break and come  
2 back for probably another hour and a half today? Or would you  
3 prefer just to find another date? We can be in touch with you  
4 to find a convenient date.

5 I'll start with Dr. Murgatroyd.

6 **MR. CANTY:** Well, Your Honour, I ... yeah, I would defer  
7 to my client. Whatever he's ...

8 **THE COURT:** All right.

9 **MR. CANTY:** Whatever is convenient for him.

10 **A.** Yeah, I ... I can make the time today.

11 **THE COURT:** Can you? All right.

12 So what I'm going to suggest is that maybe we could take a  
13 break for maybe for about 20 minutes. Let everyone just kind of  
14 stretch a little bit, that's going to get us to 4:30 and we'll  
15 come back and we'll continue at 4:30.

16 I'm assuming that that's going to work for counsel as well.

17 **MR. RUSSELL:** I do know, Your Honour, I've been speaking  
18 to Mr. Murray, in terms of ... depending on what counsel feel, I  
19 mean obviously they'll have questions as well, is Dr. Njoku we  
20 anticipate will be a bit shorter tomorrow, so there will be some  
21 time at some point tomorrow. But depending on how everyone is  
22 ...

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1           **THE COURT:**       I think that what we'll do is ... because  
2 Dr. Murgatroyd indicated he was available and Mr. Canty is  
3 available as well, I think the easiest and most predictable  
4 thing is to come back this afternoon at 4:30 and we'll continue  
5 'til we're done today.

6           All right, thank you for your consideration. I appreciate  
7 it.

8 **COURT RECESSED (16:12 HOURS)**

9 **COURT RESUMED (16:32 HRS)**

10           **THE COURT:**       Thank you. Ms. Ward?

11           **MS. WARD:** Ms. Grant.

12           **THE COURT:**       Sorry.

13           **MS. GRANT:**       Thank you, Your Honour.

14           **THE COURT:**       Yes.

15

16                                   **CROSS-EXAMINATION BY MS. GRANT**

17

18           **MS. GRANT:**       Dr. Murgatroyd, can you hear me?

19           **A.**       Yes.

20           **Q.**       Hi, my name is Melissa Grant and I'm representing the  
21 Attorney General of Canada. We're representing the various  
22 federal entities that are involved in the Inquiry, including CAF

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1 and VAC. And a couple of questions for you today, this  
2 afternoon. Thank you for your patience. And I'll apologize  
3 that some of these may be a bit disjointed because I was making  
4 some notes as my friend, Mr. Russell, was speaking.

5 So just starting off, with respect to occupational stress  
6 injury clinics, with respect to the clinic that you worked at,  
7 was that part of like a network of clinics across Canada for  
8 veterans and RCMP officers?

9 **A.** Yes, there is, I believe, ten across Canada. Ten  
10 clinics across Canada and that's excluding the satellite  
11 offices. And I don't know how many satellite offices there are  
12 across Canada but, yes, it's a network of clinics.

13 **Q.** And is it your understanding that those clinics are  
14 provincially operated but funded by Veterans Affairs Canada?

15 **A.** Yes, exactly. That's my understanding.

16 **Q.** And would that be your understanding as to why  
17 admission to such clinics would be restricted to veterans or  
18 RCMP officers?

19 **A.** Yes.

20 **Q.** And is it your understanding that if someone attends  
21 that clinic there wouldn't be a direct cost to that person out  
22 of pocket?

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1           **A.**    Exactly.

2           **Q.**    Okay. Can you ... you talked earlier about the  
3 specialized multi-disciplinary model of care that you provide at  
4 the OSI clinic. Can you just tell us a little bit about - and  
5 this may kind of tread into your current job, but what ... if  
6 I'm a municipal police officer or a firefighter or someone who  
7 works in the province as a first responder who may expect to  
8 encounter an occupational stress injury in your province where  
9 you are in New Brunswick, what options are available to those  
10 people who are not veterans or RCMP officers?

11          **A.**    Right, that's a good question. They may be able to  
12 access through their insurance private services in the private  
13 setting. And so, of course, you know, we have services here at  
14 the clinic. I wouldn't say that that's typically the clientele  
15 that we see, because my sense is that they would have insurances  
16 that cover those types of services.

17          **Q.**    And in having such insurance, is there any entity that  
18 you're aware of that operates like an OSI clinic where you have  
19 the one-stop shop for psychiatrists, psychologists, and other  
20 mental health team members?

21          **A.**    Hmm. Not to my knowledge. Certainly you have clinics  
22 of, you know, a group of clinical psychologists, for example,

**DR. MATHIEU MURGATROYD, Cross-Examination by Ms. Grant**

1 you know, a private setting like that. It's possible I'm ...  
2 you know, I'm unaware of, you know, clinics that might have more  
3 of that inter-disciplinary ...

4 You know, I mentioned at the very onset WorkSafe New  
5 Brunswick, right. And so the program that I was working in at  
6 that time was maybe such an entity that was covered by ... it  
7 was ... you know, it's a publicly funded, right, or it's an  
8 insurance, WorkSafe New Brunswick, in that, you know, they could  
9 access services through WorkSafe New Brunswick. But other than  
10 that nothing comes to mind.

11 **Q.** Okay. And that would be ... I had mentioned other  
12 first responders, but for the general population as well who may  
13 have a mental health challenge or PTSD, they would be accessing  
14 provincial healthcare services, correct?

15 **A.** Sure. Yeah.

16 **Q.** Or if they had insurance maybe through their work they  
17 could access private ... people privately?

18 **A.** Yes.

19 **Q.** Earlier you were asked whether VAC had ever reached  
20 out to you sort of automatically. I guess would you agree that  
21 in order for someone to be at the OSI clinic VAC would have had  
22 to have approved their referral in the first place?

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1           **A.**   A lot of the referrals that we would get would be from  
2 Veterans Affairs directly, but we would also receive them from  
3 the base, right. And so when those happen, you know, I don't  
4 know ... again, it probably be a better question for management,  
5 you know, if there is kind of like a communication happening  
6 between the Department of National Defence and Veteran Affairs  
7 in that scenario, right, where the ... you know, the individual  
8 is being seen at on-base, you know, as they're releasing and for  
9 the continuity of care they're being referred to us, they don't  
10 yet have a VAC case manager. But I'm sure Veterans Affairs must  
11 be involved somehow as part of the ... that plan.

12           **Q.**   Okay, fair enough. And we heard from Dr. Joshi this  
13 week and he had said that it was his practice that when he knows  
14 someone is getting ready to release from the Forces, that he  
15 likes to make his referrals a couple of months before that  
16 release date so that there is that continuity of care. And so  
17 ...

18           **A.**   Mm-hmm.

19           **Q.**   ... in this case, in looking at the dates we see that  
20 ... our understanding is that Lionel Desmond released from the  
21 Forces ... sorry, I'm just going through my notes, it was June  
22 16th, 20- ...

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1       **THE COURT:**       Thereabouts, yes, that's ...

2       **MS. GRANT:**       Yeah, June ...

3       **THE COURT:**       ... a close date.

4       **MS. GRANT:**       ... 16th, 2015. And ...

5       **A.**       Mm-hmm.

6       **Q.**       ... then you had telephone conversations with him, we  
7 understand, in May of that year.

8       **(16:40)**

9       And then your original appointment with him was June ...  
10 was supposed to be June 22nd, is that right? Because we heard  
11 earlier I think that he had missed that first appointment but  
12 then you saw him on the 24th.

13       **A.**       Yeah, that sounds about right. The first session was  
14 in June, yes.

15       **Q.**       So within a week ...

16       **A.**       Yes.

17       **Q.**       Thank you. So within a week of ... a week or so of  
18 Mr. Desmond's release you were seeing him at the OSI clinic?

19       **A.**       Yeah.

20       **Q.**       So ...

21       **A.**       And he would have had that intake prior to that, yeah.

22       **Q.**       Thank you.

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1           Just to talk a little bit about ... you had mentioned in  
2 your evidence that Marie-Paule Doucette was Lionel Desmond's  
3 eventual case manager, is that right?

4           **A.**    Yes.

5           **Q.**    And at one point you had said that Ms. Doucette was  
6 involved in the client's care, and I just wanted to clarify that  
7 "care" in that sense is not healthcare per se? She's not a  
8 healthcare provider.

9           **A.**    Yes, that's a nice clarification.    Yeah.

10          **Q.**    And earlier when you talked about receiving that phone  
11 call from Ms. Doucette about her concerns that Mr. Desmond was  
12 going to change his mind about not wanting to attend at Ste.  
13 Anne's, did you feel that she was appropriately caring and  
14 concerning with respect to Mr. Desmond's care?

15          **A.**    Yeah, absolutely. I felt that, you know, in reaching  
16 out to me, right, to sort of kind of look into the situation I  
17 felt that she was being responsive.

18          **Q.**    And did you under- ... did you know or understand that  
19 she actually drove Mr. Desmond to the airport so that he could  
20 fly to ... from Fredericton to Montreal?

21          **A.**    That's my understanding.

22          **Q.**    And that she, like you, also kept Mr. Desmond on

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1 longer as a client to bridge that transition from New Brunswick  
2 to Nova Scotia?

3 **A.** Yeah, again that's my understanding.

4 **Q.** And you noted that the circumstances of this case were  
5 a bit unusual in that respect.

6 **A.** Absolutely. Yeah.

7 **Q.** Thinking about all that you and Mr. Russell discussed  
8 today about the specialized treatment that is available to  
9 veterans at an OSI clinic, would you agree that it ... you would  
10 have felt better or would have wished that Mr. Desmond had made  
11 a different choice and that he had chosen to take that ... make  
12 that trip to Halifax or make those trips to Halifax?

13 **A.** I would have felt better about it, I think that's a  
14 fair way of putting it. You know, as I kind of explained there  
15 with Mr. Russell, especially the psychiatric follow-up. Of  
16 course, you know, we know that therapy, especially when, you  
17 know, we're talking about, you know, trauma-focussed therapy  
18 it's a big commitment unless they have ... and then this is not  
19 something that I talked about at all, I think, you know access  
20 to, you know, kind of virtual care, those types of methods, kind  
21 of looking into those services. You know, that could have been  
22 an option, right, for therapy with a clinician in Halifax.

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1 But, you know, having somebody in the community is, from a  
2 therapy standpoint, you know, that's kind of I think what we  
3 were expecting. But having a psychiatrist at the OSI clinic,  
4 having that expertise and that connection would have felt better  
5 about that.

6 Q. And looking at the area where Mr. Desmond ultimately  
7 decided to reside, which was in Antigonish/Guysborough area of  
8 Nova Scotia, you would agree that there are issues ... probably  
9 in New Brunswick like in Nova Scotia, issues accessing  
10 healthcare in a rural setting?

11 A. Without a doubt, it's ... and again, I kind of go back  
12 to that point in ... I don't know how much detail that you guys  
13 might need. You know, the virtual care telehealth was a service  
14 we were offering to provinces such as Newfoundland and PEI and  
15 rural New Brunswick, that was ... you know, there was ... that  
16 was our mandate, that was the understanding, given that those  
17 provinces didn't have OSI clinics - and so whether Halifax, Nova  
18 Scotia was doing that I'm not sure - to be able to connect with  
19 veterans and, you know, RCMP who are maybe in those rural areas.  
20 And, of course, as you know we're in this pandemic we're doing  
21 that more and more, right, so it's kind of the wave of the  
22 future in being able to connect with folks in rural areas.

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1           **Q.**    Yes, Dr. Rogers was mentioning yesterday that, you  
2 know, thinking in pre-COVID there was much more of a reluctance  
3 to engage in that sort of video-type, like we're all doing  
4 today, but that's become more frequent but it wasn't really ...

5           **A.**    Yes.

6           **Q.**    ... in ... wasn't really the go-to back then when  
7 these events were happening, right?

8           **A.**    Right.

9           **Q.**    And so Mr. Russell had asked you some questions about  
10 the kind of therapist that would be sort of the ideal person,  
11 community-based therapist, for Lionel Desmond when he came out  
12 of the stabilization program and talked about, you know, you had  
13 agreed that someone with obviously experience treating PTSD and  
14 ideally someone who had experience treating veterans.

15           I guess in going back to my previous question about the  
16 rural healthcare setting, if ... you know, I guess you'd agree  
17 that if there are only a few people in a rural setting that  
18 maybe your options would be more limited or restricted in who  
19 could take you on as a client.

20           **A.**    Yeah, it's challenge, I would agree to that. I  
21 remember some talk in ... this is really just kind of in passing  
22 that ... and I don't know the area too, too well, but that St.

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1 FX, is not too far, is that right?

2 Q. Yes. Yeah.

3 A. Right. And so, you know, the possibility that through  
4 the university that there might be somebody, you know, that  
5 might be familiar with that clientele but we weren't sure. And  
6 at that point it is usually, you know, the case manager in the  
7 back that's kind of like trying to do that work of kind of  
8 connecting veterans to the appropriate services, yeah.

9 Q. Are you familiar with the name Helen Boone at all? Is  
10 that a name that's familiar to you?

11 A. No.

12 Q. Okay. So our understanding is that she was eventually  
13 ... "appointed" may not be the right word, but hired as Lionel  
14 Desmond's clinical care manager.

15 A. Right. Okay.

16 Q. Just in terms of the previous discussion that you had  
17 with Mr. Russell about a mental health team, I just wanted to  
18 know if you had any familiarity with those ... that name?

19 A. Yeah. No, not the name but I think I heard that a  
20 clinical care manager had been set up. Maybe it was even  
21 through these proceedings here.

22 Q. Just turning the focus a little bit, I wanted to

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1 discuss the issue of medical marijuana. You had mentioned that  
2 Lionel Desmond was seeing Dr. Paul Smith, is that correct?

3 **A.** Yes.

4 **Q.** And that he was ...

5 **A.** Yes.

6 **Q.** ... not affiliated with the OSI clinic?

7 **A.** No.

8 **Q.** And he's not affiliated with the Canadian Armed  
9 Forces?

10 **A.** No.

11 **Q.** We heard evidence from Dr. Rogers that she and her  
12 colleagues were quite ... I think she used the word "distressed"  
13 at the amount of marijuana and the degree to which that was  
14 being prescribed to veterans. Did you and your colleagues share  
15 those kinds of concerns at the time?

16 **A.** Yes. You know, we ... I don't have a back- ... you  
17 know, I've never worked in a psychiatric unit but I have  
18 colleagues and friends who have and, you know, I've been told  
19 that when it comes to substance-induced psychosis, you know,  
20 it's something that is seen regularly, right. And so, you know,  
21 that's one of the concerns, right, when we're not sure, you  
22 know, how much they are ... and I know it's a huge debate there,

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1 you know, and there are advocates out there.

2 **(16:50)**

3 But from a clinician's standpoint and kind of knowing that,  
4 having seen that or at least, you know, colleagues who have seen  
5 that, it is concerning. And then, you know, also looking at  
6 potential treatment interference, I think I alluded to that  
7 earlier, right, is there an impact on day-to-day function.

8 I know that it offers relief for some folks and that's  
9 great, you know, for those that it offers relief, but we know  
10 that it can also have these ... the impact on cognitive  
11 functioning and day-to-day functioning.

12 And just briefly, I know Lionel and I never got there, but  
13 when we're engaging in trauma-focussed therapy, you know,  
14 smoking marijuana or even taking an Ativan that's prescribed as  
15 needed, you know, if I've got a client that's, you know, taking,  
16 you know, those types of medications right before coming in to a  
17 session, you know, we're unable to do the processing, right and  
18 the emotion regulation which is part of the therapy process. So  
19 these are some of the main concerns that we had.

20 **Q.** Thank you. And I think earlier you had said I don't  
21 know how much you want to know but I think part of this exercise  
22 for us is learning, opportunity, and education, so if there's

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1 anything you think that we should all know, you know, I would  
2 say don't hesitate in answer ...

3 **A.** Okay.

4 **Q.** ... in answering any of my questions, for sure.

5 **A.** Thanks.

6 **Q.** One question I have, in terms of a treatment  
7 relationship with somebody. Would you agree that you have a  
8 professional obligation as a clinician, as a ... whatever the  
9 medical healthcare person is, doctor, nurse or clinical  
10 psychologist like yourself, to not treat someone if you felt  
11 their condition was beyond your scope of practice?

12 **A.** Yeah, we ... you know, in terms of ethically speaking,  
13 right, if they're ... you know, if I'm, you know ... I'm trying  
14 to find an example there. But kind of like the example that Mr.  
15 Russell kind of used earlier, right, if, you know, certain  
16 training or certain background, right. Here's an example, you  
17 know, I wouldn't be qualified to treat a child because that's  
18 just not part of, you know, what I studied for and trained for.

19 **Q.** Thank you. Yeah, and Dr. Rogers gave us an example, I  
20 think, in terms of being a child clinical psychologist, there's  
21 a different scope of practice there so ...

22 But in terms of treating someone with PTSD, it might be a

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1 benefit to treat ... to have extensive experience with veterans,  
2 but if you are seeing somebody and are the only person in the  
3 community and that person has extensive experience treating PTSD  
4 but perhaps not in the military context, that's not necessarily  
5 something that is odd to you. Is that right? Or would you  
6 agree?

7 **A.** Yeah. I mean, again, if they've been trained in, you  
8 know, these modalities, right, and they've got the experience  
9 delivering these treatment modalities, I don't think I'd say  
10 that I'd be concerned, you know, if they've got that experience,  
11 right, that they'd be able to treat a military veteran with  
12 PTSD.

13 **Q.** When we're thinking about the Ste. Anne experience and  
14 that in talking about it being a stabilization unit and how you  
15 had indicated that you'd never quite been able to achieve that  
16 stabilization goal and that was the goal of the admission to  
17 Ste. Anne's and we ... and heard that Mr. Desmond seemed to be  
18 improved when he did leave that program albeit earlier and  
19 against advice to leave ...

20 **A.** Mm-hmm.

21 **Q.** Would it be your understanding that individual  
22 psychotherapy would then have been a natural next step?

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1           **A.**    Yes, that ... you know, again, trying to reinforce  
2    what he's learned and maintain that, right. And if we're able  
3    to maintain that, the, you know, day-to-day functioning,  
4    activities of daily living, you know, that has improved, which  
5    again, we're kind of talking about the person is stable, then we  
6    can kind of get to that, you know, trauma-focussed therapy to  
7    address the PTSD ... that exactly.

8           **Q.**    And then you get ... I wrote down what you said  
9    earlier about the goal becoming your own mini therapist, I like  
10   the sound of that. I think everybody should maybe be aspiring  
11   to that when they're on the right track. But I guess my  
12   question is what ... when you're thinking about those tools and  
13   becoming sort of aware, what role do you see the patient  
14   playing?

15           So we've talked a lot about the role today, your role, and  
16   the role of others, and the role of psychiatrists, but what's a  
17   patient's role in navigating a mental health challenge?

18           **A.**    Yeah, that's a good question. Yeah.

19           **Q.**    I guess I ... If I could ask it a different way ...

20           **A.**    Yeah.

21           **Q.**    ... just to maybe help you out. It's not a passive  
22   experience. You're not going to get ... see improvements by ...

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1           **A.**    Yeah.

2           **Q.**    ... you know, not taking steps.

3           **A.**    Yeah. I was going to end up going there. I was  
4 thinking kind of like the context of, you know, somebody in the  
5 general population is certainly a little bit different than, you  
6 know, a veteran kind of releasing who's ... it almost seems like  
7 there was an expectation. You're coming out of base, right,  
8 there's an expectation yeah, kind of going in to services at the  
9 OSI. There is certainly an expectation, right. And you know  
10 what, if there's this inconsistency, the disengagement, we're  
11 not doing the therapy justice.

12           And the fear is, you know, for me, is that if ... it's  
13 sending a message to the individual that, you know, therapy  
14 might not actually work, right. You know, if this is what  
15 therapy is about, right, well, I'm not improving right now. So  
16 if we're not doing therapy justice well maybe we actually need  
17 to call it off, right. And so, you know, I have these  
18 conversations every week, I think, like with, you know, one of  
19 my clients.

20           You know, with Lionel, I think that the stress that he was  
21 going through and the, you know, the concern that we had, you  
22 know it never got to that point where, you know, I kind of made

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1 that decision. I think we were thinking about maybe referring  
2 him to Nova Scotia because he was spending so much time there,  
3 but I don't think we got to a point where, you know, he's no-  
4 showed five/six times we're going to close him, I think we felt  
5 we had a responsibility. Ste. Anne's was coming up, you know,  
6 let's see if we kind of get him there.

7 But certainly I agree with you that there needs to be a  
8 commitment in kind of closing a file, having that discussion,  
9 you know, because there's a responsibility there on the  
10 patient's end, absolutely.

11 Q. Turning to the issue of hospital records. I guess I'd  
12 suggest to you that if you're asked a question "is more  
13 information ... is having more information better" that's kind  
14 of a question where you're going to say yes, if I could be blunt  
15 about that. As a medical professional, more information is  
16 better, and you've said that earlier.

17 A. Sure. Yes.

18 Q. I think in any profession we'd make the same  
19 determination.

20 In that vein, though, the lack of somebody's entire,  
21 complete medical history would not be ... would not prevent you  
22 from treating somebody, correct?

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1           **A.**    Correct.

2           **Q.**    And that sometimes you might treat somebody and that  
3 you don't have any background information, perhaps other than  
4 what the person is disclosing to you?

5           **A.**    Yeah, in some circumstances, sure.  Yeah.

6           **Q.**    So you take that ... as part of your obligation as a  
7 clinician, you take your patient as you find them, so to speak?

8    **(17:00)**

9           **A.**    Mm-hmm.  Yeah, for example, you know, someone that's  
10 ... I didn't talk about this too, too much because, you know, he  
11 wasn't that kind of referral.  But if we're getting a referral  
12 for somebody that, you know, have absolutely no contact with  
13 mental health, you know, prior, right, an assessment for  
14 disability, in other words.  You're receiving this client and  
15 there's almost nothing in the file, right?  There's ... you  
16 know, VAC is sending us, you know, information that they have  
17 but, you know, there's almost nothing.  So that's why, you know,  
18 the collateral information is so important at that stage.  But  
19 like you mentioned, you're kind of almost starting from scratch.

20           **Q.**    So if I was one of your patients and I'm telling you,  
21 Oh, this thing happened to me where I was ... I went to the ER  
22 at the Chalmers Hospital, for example, in Fredericton, there's

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1 nothing preventing you, other than my consent, to you obtaining  
2 those records. Is that ... was that sort of fairly common, that  
3 you'd find out sort of sources of potential useful information  
4 that you have ... you'd go get those pieces of information?

5 **A.** Yeah, with the client's consent we could go get that  
6 information.

7 **Q.** And you had various discussions with Mr. Desmond as,  
8 I'm assuming, with all of your clients. You'd noted earlier  
9 about confidentiality and the limits of confidentiality.

10 **A.** Yes.

11 **Q.** And I guess just a question from a mental health  
12 perspective and something that Dr. Rogers had alluded to in her  
13 testimony that, you know, you explain to your patients that if  
14 they pose an imminent risk of harm that you would have a duty to  
15 warn. So the patient would be familiar with that concept.  
16 Correct?

17 **A.** Yeah, it's something that we go over at the onset.

18 **Q.** So is one of the challenges that you face dealing with  
19 mental health challenges is that you have to rely quite a bit on  
20 the ability of your ... or the truthfulness of your patient or  
21 their candour?

22 **A.** Yeah, it's certainly a limitation. Yes.

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1           **Q.**   And is it fair to say if somebody had made up their  
2 mind to either self-harm or harm someone else that they would  
3 likely be aware that if they divulged that to you that you would  
4 have an obligation to take some steps? Is that fair to say?

5           **A.**   Absolutely. Yeah, that's a risk.

6           **Q.**   And just turning to ... turning back to the experience  
7 at Ste. Anne's. There's been some suggestion that we've seen in  
8 the media that ... a phrase that Lionel Desmond was sort of  
9 "allowed" to leave Ste. Anne early, and I guess I just want your  
10 comment on that and whether that goes to autonomy or choice or  
11 that sort of thing. Like, what ... as a clinician, you can only  
12 do so much, and so I guess I'm just wondering if you have any  
13 comment on that sort of concept.

14          **A.**   Yeah, I think I'd agree with that. You know, you've  
15 got a host of clinicians there, professionals, right, that are  
16 assessing. And so you know, if they were really concerned, you  
17 know, when it comes to whether they need to either keep them or,  
18 you know, hospitalize them, you know, they could have done that,  
19 right? And ultimately, you can't force someone to stay, you  
20 know? So there's a choice there, right? And my understanding  
21 is that that's exactly what happened, right? He chose to leave  
22 a few weeks in advance against medical evidence. That's my

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1 understanding.

2 Q. So there ...

3 A. But that they weren't ...

4 Q. Go ahead.

5 A. Oh, yeah, but that they ... it doesn't seem like they  
6 had concerns, you know, that he was a risk, you know, to the  
7 point where they needed to, you know, kind of hold him so to  
8 speak.

9 Q. So when you say hold him is that an involuntarily hold  
10 to hospitalize somebody essentially against their will?

11 A. As an example, yeah.

12 Q. And it may depend on the province, but there are sort  
13 of strict criteria for when you can involuntarily hospitalize  
14 somebody.

15 A. Yes, and you know, that would be a better question for  
16 a physician, Dr. Njoku, but yes.

17 Q. One of the things we heard from Dr. Rodgers which I  
18 thought was interesting was that sometimes, you know, sort of  
19 stabilization is a goal and it's a goal that we've talked about  
20 for Ste. Anne. But that long-term sort of in-patient  
21 hospitalization may not be the best thing long-term for PTSD  
22 patients because they have to learn how to live in the real

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1 world where they have the daily challenges and stressors of  
2 life. Would you agree with that?

3 **A.** Mm-hmm. Yeah. No, I agree with that. That's always  
4 something that we consider, right? And that is ... you know,  
5 when we're kind of receiving sort ... you know, for lack of  
6 better terms, receiving the client back, right? It's just ...  
7 and you've taken this client out of their environment, you know,  
8 the day-to-day stress, the stressors that are going to ...  
9 they're going to be there, right? That's part of life. And  
10 then you know, almost kind of in an artificial setting, right?  
11 It's ... it is a concern. It's something that we consider.

12 You know, there is also kind of like the flip-side where,  
13 you know, we've got an individual here who's ... who kind of ...  
14 we really desperately need to kind of give them a break, and  
15 because of the circumstances we're just not getting there,  
16 right? So kind of see it on both sides.

17 **Q.** And would you agree that there's no ... I mean there  
18 are therapies that you've talked about, therapies and modalities  
19 that you use, but would you agree that there's no real one-size-  
20 fits-all approach to a person who presents with a mental health  
21 challenge?

22 **A.** Yeah, I mean there's always going to be variability

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1 depending on the person that you've got in front of you. You  
2 know, there is certainly more generalist approaches, right? Out  
3 there that, you know ... that you can kind of mold and so that  
4 it is ... it kind of fits with that individual. Don't know if  
5 that answers the question.

6 Q. That's fine. There is also ... Dr. Rodgers was saying  
7 yesterday that it's the act that, you know, we are having an  
8 inquiry about is actually a very rare occurrence. So someone  
9 committing a homicide is very rare, and so the research in terms  
10 of how to predict that is difficult sometimes. Would you agree  
11 with that?

12 A. Yeah, absolutely. We talk about risk factors, right?  
13 But when it comes to predicting, right, you know, it's very  
14 difficult, absolutely.

15 Q. So as laypeople who don't deal with this sort of day-  
16 to-day assessment of whether someone has a suicidal ideation or  
17 homicidal ideation, when, you know, a layperson reads on a  
18 report that there is homicidal ... someone is thinking about  
19 homicide and that a medical professional then sort of judges  
20 that risk to be low or that they're not a risk to harm people, I  
21 think that laypeople might have a problem conceptualizing that.

22 So I'm reading on a report that says this person is

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1 expressing homicidal thoughts. So you know, a layperson says,  
2 Well, why aren't you calling the police, or, Why aren't you  
3 doing something, or, Why aren't you involuntarily holding this  
4 person? So I'm just wondering if you could maybe put some  
5 context around what that looks like in practice about your  
6 assessments that you do.

7       **A.** Yeah, you know, and I've certainly kind of touched on  
8 that a little bit earlier. You know, homicidal thoughts, you  
9 know, thoughts of violence, you know, are less rare than we  
10 think, right? You know, kind of just having those thoughts.  
11 But you know, there's a difference between, you know, fleeting  
12 thoughts, right, and then, you know, and then deliberate  
13 rumination, right?

14       So as the intensity ... you know, that's where you need to  
15 kind of look at some of the other risk factors that I would have  
16 identified earlier, right? So it's really assessing whether  
17 there's a plan. It's really kind of having those difficult ...  
18 you know, asking those difficult questions, you know, in terms  
19 of where, how, and when, intended ... you know, intended victim.  
20 You know, is there an access to means? You know, has there been  
21 preparation, right? We're doing this, you know, for a  
22 homicide/suicide.

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1 (17:10)

2 And then as I think I identified, you know, when it comes  
3 to internal/external environmental risk factors and protective  
4 factors, right? And so we know that with mental health, right?  
5 It is a risk factor in itself, right? And so it will increase  
6 that risk, right? So it is part of our ... you know, our role,  
7 right? To kind of check in on that. And there is certainly a  
8 judgment call that kind of happens, right? Whether or not to,  
9 you know, kind of act out and call the authorities or kind of  
10 have some kind of plan there.

11 Q. And ... but you would agree on the same side of the  
12 things that you are not there to police people 24/7. That's not  
13 your job.

14 A. Yeah. No, we're not a ... I mean we're not a crisis  
15 centre, right? We are an out-patient clinic, you know, 8 a.m.  
16 to 4:30 type of thing. And so you know, there are the emergency  
17 services and numbers that we will give them access to that. We  
18 talked about the crisis line, right? And yeah, we have  
19 resources and services if we deemed that that individual is at  
20 risk. But yeah, there's that element of kind of accountability  
21 and responsibility on the client's end as well.

22 Q. And thinking about mental health challenges and ...

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1 sometimes can present a bit of a roller-coaster in terms of  
2 people having good days and bad days. Would you agree with the  
3 sentiment that more treatment is not always indicative of better  
4 outcomes?

5 **A.** Can you repeat that? Sorry.

6 **Q.** Yeah. I guess I'm saying more treatment does not  
7 always result in better outcomes or resolution of the mental  
8 health condition.

9 **A.** That's interesting. I mean with ... you know, it's  
10 more in the media now, right? When it comes to mental health  
11 and, you know, self-care and things of that nature, right? So  
12 this idea that everything needs to kind of be treated where, you  
13 know, some of these mental health challenges might just be  
14 natural processes, right? And then just kind of natural day-to-  
15 day stress, right?

16 So ... and this idea that everything needs to kind of be  
17 treated, I think I'd agree to that. I don't know if that's kind  
18 of what you were looking for ...

19 **Q.** Well, that's your answer and that's fine. I guess  
20 what I'm suggesting to you sort of overall is that sometimes not  
21 everybody gets better.

22 **A.** When it comes to treatment.

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1 Q. Yes.

2 A. With the trajectory. Sure, you know, sometimes, you  
3 know, we don't achieve the goals that were set out and, you  
4 know, for whatever reason - it might be life circumstances - the  
5 individual is worse off by the end of it, you know? I suppose  
6 that that happens.

7 Q. And you ... all you can do is your best, I guess.  
8 You'd agree with that?

9 A. Certainly, I would agree with that, yes.

10 Q. And can you just tell us if you know, but what ... is  
11 there one thing or is there a predictor, the greatest predictor  
12 of sort of success in terms of somebody resolving a mental  
13 health condition like PTSD?

14 A. Oh, that's a good question. I could offer a guess.  
15 I'm not a hundred percent on that, no.

16 Q. Okay.

17 A. I know that resilience, you know, and treatment  
18 engagement and therapeutic alliance are really important but I'm  
19 not sure exactly on the top predictor.

20 Q. What about a strong social support system? How  
21 important is that?

22 A. Yeah, that's another very important one, absolutely.

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1 You're right. We've got individuals, right, and I'm thinking of  
2 other, you know, clients that, you know, were the success  
3 stories, if you will, right? Where they kind of come into  
4 treatment where, you know, it's really the PTSD and it's, you  
5 know ... sometimes we kind of call it a clean diagnosis as is  
6 ... as if, you know, that's really the problem at hand.

7 But you know, around that individual the supports are in  
8 place and are doing well otherwise. They might even have a  
9 part-time job, right? And it is just ... you know, that is the  
10 goal while working on the PTSD, right? So the support is really  
11 important, yes.

12 Q. Those are all of my questions. Thank you very much,  
13 Dr. Murgatroyd.

14 A. Thanks.

15 **THE COURT:** Thank you, Ms. Grant. Mr. Anderson?

16 **MR. ANDERSON:** No questions, Your Honour.

17 **THE COURT:** All right. Thank you. Mr. Macdonald?

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

19 **THE COURT:** All right. Thank you.  
20  
21  
22

DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Macdonald

CROSS-EXAMINATION BY MR. MACDONALD

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(17:16)

MR. MACDONALD: Good afternoon, Dr. Murgatroyd.

**A.** Hi.

**Q.** My name is Tom Macdonald and I am the lawyer for the Borden family. So the late wife and daughter of Cpl. Desmond and I share co-representation of the little girl with my colleague, Tara Miller.

Is it fair to say that from your sessions with Cpl. Desmond over the 16 months that you were treating him, whether they were in person or on the phone, that he was displaying anger toward his wife?

**A.** Yeah, it would be fair to say that. Maybe not every session but certainly it was something that was recurrent.

**Q.** Yes. I wanted to take you to exhibit ending in 244. That's your ... the health records from Horizon, and to page 75. Mr. Russell took you through some of this earlier. Please tell me when you're there.

**A.** Yes.

**Q.** So this is your progress note of November 9th, 2015. Correct?

**A.** Yes.

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1           **Q.**   And under the box that says, "Focus - Client contacted  
2 writer. In distress. Appointment scheduled." That was, as I  
3 understood from your evidence to Mr. Russell, that was a  
4 telephone call?

5           **A.**   Yes.

6           **Q.**   From Cpl. Desmond to you?

7           **A.**   Yes.

8           **Q.**   Was he agitated, do you recall, on the call?

9           **A.**   In terms of my recollection, you know, for this  
10 specific entry, I don't recall. However, you know, if I'm  
11 looking at the ... you know, the content here, I imagine that  
12 there was some distress, yes.

13          **Q.**   Okay. Is it fair to say, or do you recall, whether he  
14 was angry on that call?

15          **A.**   No specific recollection but, you know, it's fair to  
16 say that, you know, there would have been anger.

17          **Q.**   Okay. Now I'm focusing on the first large paragraph  
18 and ...

19          **A.**   Mm-hmm.

20          **Q.**   ... so he's ... your notes are reflecting that he's  
21 discussing a number of things. He's ... and I'm paraphrasing,  
22 Doctor. He's discussing the Regina trip. She bought tickets,

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Macdonald**

1 meaning his wife. She used his money. He reported being ...

2 I'm reading here now directly:

3 He reported being really upset with his wife  
4 and his wife's parents. He said they are  
5 unsupportive and do not care about his  
6 mental health concerns. Mr. Desmond  
7 admitted to having fleeting homicidal  
8 thoughts but no intent. He said he would  
9 not hurt anyone. He indicated his daughter  
10 remains his number one priority.

11 And then we go down a little bit and he says ... or sorry,  
12 your notes say, "Due to the lack of support he said he is no  
13 longer staying with his wife at her parents' place ..." and he  
14 goes on to other things. I know in response to ... have I put  
15 that accurately? I'm reading verbatim, obviously, for some of  
16 it. You're okay with the way I've presented it so far?

17 **A.** Yes.

18 **Q.** Sure. So I know Mr. Russell took you through this and  
19 I know you indicated you didn't know or could not remember  
20 whether he had named anyone or referred to anyone, and if he had  
21 you told us about your professional obligation under those  
22 circumstances and what you would have done. So I'm not

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1 quarreling with any of that, obviously.

2 (17:20)

3 A. Mm-hmm.

4 Q. But you did indicate to Mr. Russell that in a later  
5 session there was reference to his time in Afghanistan and maybe  
6 that reference on this page to the homicidal thoughts could have  
7 been tied to Afghanistan. Do you remember that?

8 A. Yeah, you know, I mentioned that earlier in my ...

9 Q. Yes.

10 A. ... testimony and it's ... you know, it's something  
11 that came up, right? And ...

12 Q. Right.

13 A. ... so I'm ... yeah, and I'm not sure here if that was  
14 the case but, you know, that was something that was clarified at  
15 a later time.

16 Q. Sure.

17 A. Yes.

18 Q. And where I'm going, Dr. Murgatroyd. There's no  
19 reference, of course, in this particular note of yours to  
20 Afghanistan. You'd agree with that.

21 A. No.

22 Q. And there's ... no as in there is no reference, right?

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1 That's what you mean?

2 **A.** Yeah, I agree with you. Yeah.

3 **Q.** Yes, and there's no reference to conflict between Cpl.  
4 Desmond and CAF members relating to racial incidents in here  
5 either, is there?

6 **A.** No, there is not.

7 **Q.** Yeah. Because when we look at this paragraph he opens  
8 it ... your notes of course. But the conversation opens with  
9 him speaking about money and then sort of directly goes to his  
10 wife and unsupportive and her parents and then he ... the note  
11 reflects the homicidal thoughts and then he comes back to he's  
12 no longer staying with his wife.

13 Isn't it reasonable to assume he may have been referring to  
14 his wife when he spoke about ... or when the note reflects  
15 homicidal thoughts? He may have been, might he not?

16 **A.** You know, I don't know if I'd want to suggest that.

17 **Q.** Wouldn't it be possible though, Doctor, in the context  
18 of this particular note. That he may have been. Not saying he  
19 was but he may have been.

20 **A.** It's possible, sure, yeah.

21 **Q.** Okay.

22 **A.** It's not something that he identified.

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1           **Q.** Understood. On those notes ... and I know Mr. Russell  
2 asked you and you explained that you would make the notes  
3 sometimes certainly within the same week but not necessarily the  
4 notes that appear here in this form, not necessarily at the time  
5 you were dealing with the patient. Is that ... do I have that  
6 right?

7           **A.** Yeah, I mean daily you're completing your note as, you  
8 know, quickly as possible, right? But sometimes there are a few  
9 days' delay.

10          **Q.** Yes. When you're doing that are you actually ... what  
11 we see here. So when you're on that phone call with him are you  
12 typing the notes as they appear here or are you writing them  
13 down and you have handwritten notes that you later transcribe?

14          **A.** Sometimes we have what we call ... you know, so this  
15 is the file and, you know, sometimes we'll have, you know, notes  
16 that we'll take as well.

17          **Q.** Yes. We've lost the video, Dr. Murgatroyd, but can  
18 you still hear me?

19          **A.** Yes.

20          **Q.** And I can hear you.

21          Your Honour, I'm quite prepared to continue if that's okay  
22 with you. Or if you want to wait for the picture to come back.

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1       **THE COURT:**       Well, just give us a second. See if ...

2       **MR. MACDONALD:** Sure.

3       **THE COURT:**       ... we can get it back. There we go. We  
4 have everybody back.

5       **MR. MACDONALD:** Oh, we're back ...

6       **THE COURT:**       Thank you.

7       **MR. MACDONALD:** ... Dr. Murgatroyd. Do you remember whether  
8 you made any other notes that day that you would have later  
9 transcribed into these notes when you were on that call with  
10 Cpl. Desmond?

11       **A.** Not to my understanding. I'm not sure on that, no.

12       **Q.** Would it be possible that you could check and if you  
13 find stuff you could advise Mr. Canty, who could advise Inquiry  
14 counsel and pass them through to Judge Zimmer? If they do  
15 exist. I'm not saying they do but if they do could you have a  
16 look for us?

17       **A.** My understanding is that this is all that exists on  
18 ...

19       **Q.** Okay.

20       **A.** On Mr. Desmond's file.

21       **Q.** All right. That's fine, Dr. Murgatroyd. Thank you.

22 I wanted to touch for a moment on the issue - and Mr. Russell

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1 took you through it - of the consent issue with Cpl. Desmond.  
2 And so at times he was consenting to sharing of information or  
3 contact with his wife and then he would rescind it, revoke it,  
4 and I took your ans- ...

5 **A.** Oh, yes.

6 **Q.** Yes, and I think your answer to ... Mr. Russell asked  
7 you. He didn't put it this way. He put it more eloquently than  
8 I would put it, but he ... the suggestion being, What did you  
9 think about that? And I think your answer was it was ... you  
10 found it challenging. Could you expand on what you meant by  
11 that and what, if anything, you draw from a patient who is back  
12 and forth with consent relating to a spouse and their treatment?

13 **A.** Yeah. You know, there was almost kind of like a bit  
14 of a ... how would you call that? You know, the collateral  
15 information is important. There is a consideration that goes  
16 into play, right? In ... especially with an individual like  
17 Lionel, you know, who has shown, you know, distress, right? And  
18 so being able to ... wanting to have that, you know, collateral  
19 information but also not wanting to impact the therapeutic  
20 alliance, right?

21 And so that's part of, you know, the ... kind of the issue.  
22 But if there is no ... you know, if he is rescinding, right,

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Macdonald**

1 there is going to be no contact, right? And so that is a  
2 challenge if you're looking for that collateral.

3       **Q.** Sure. I wanted just to ask you about your referral  
4 letter to VAC ultimately recommending that he be sent to Ste.  
5 Anne's and you listed a number of factors. Mr. Russell took you  
6 through, of course, the contents of your letter. We can go  
7 there if we need to but I'm not saying that you do. What I did  
8 notice, there was no specific reference to - my word - anger  
9 toward his wife or specific spousal issues. Is there a reason  
10 that that may have not been specifically referred to in the  
11 various list of factors that you went through why he should be  
12 going to Ste. Anne's?

13       **A.** Yeah, and, you know, that ... you might have caught a  
14 mistake there. Certainly, at that point that might have been  
15 something that would have been worth mentioning. I don't have  
16 it in front of me here.

17       **Q.** It's page ... you don't ... only if you need to look  
18 at it, Dr. Murgatroyd. Page ...

19       **A.** Yeah.

20       **Q.** ... 95. It's actually on 97.

21       **A.** Mm-hmm.

22       **THE COURT:** Bring it up.

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1           **A.** Right. You know, I think I make reference there to  
2 the lack of social ... the support network. Yeah, I don't see  
3 anything on anger here. It might have been worthwhile, you  
4 know, kind of touching on that. That's a good point, and  
5 certainly, look, I mean that's something that they're going to  
6 be assessing on their end and it seems like he was ... you know,  
7 from what I received, it seems like he was open and, you know,  
8 kind of transparent about, you know, some of the issues going on  
9 interpersonally.

10           **Q.** Thank you. I know that you mentioned, I believe,  
11 earlier that this referral to Ste. Anne's was the only one you  
12 had done so far in your practice. You haven't done another one  
13 yet. Is that right?

14           **A.** Correct.

15           **Q.** Yeah. Do you think it would be worthwhile for the  
16 Inquiry going forward that ... by way of a recommendation or  
17 otherwise, that if ... and we're talking about, of course, Cpl.  
18 Desmond. But if a Forces member who was a combat veteran like  
19 Cpl. Desmond was, had PTSD and other issues but included in that  
20 long list of issues were spousal issues that it would be  
21 worthwhile to specifically flag - my word - that in referral  
22 reports or referral requests I should say?



**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Macdonald**

1 Brunswick clinic. I'm looking at ... in particular at page 22.  
2 You went through them this morning with my friend, Mr. Russell.  
3 There were a number of different consents that were completed.  
4 This one is a consent ... do you have it in front of you?

5 **A.** Yes.

6 **Q.** Okay, and it effectively says: "I consent to allow the  
7 Fredericton OSI clinic to contact staff at the referral agencies  
8 of ..." and then Veterans Affairs is listed, DND is listed, and  
9 RCMP.

10 **A.** Mm-hmm.

11 **Q.** It's signed, we assume, by Lionel Desmond and dated  
12 June 24th, 2015. And then there's a witness, KH. Do you know  
13 who that witness would have been?

14 **A.** That would have been an administrative assistant.

15 **Q.** Okay. I find it interesting that the only tick-box  
16 for consent to allow the Fredericton OSI clinic to contact staff  
17 is at Veterans Affairs and that the Department of National  
18 Defence is not checked off. So I take from that that in the  
19 absence of permission to contact the Department of National  
20 Defence, which in this case was the referring agency to you from  
21 Dr. Joshi, I take from that, that you nor any of your colleagues  
22 at OSI New Brunswick would have been able to speak to Dr. Joshi

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1 and/or Dr. Rodgers or anybody at the Canadian Armed Forces. Is  
2 that a fair assessment of the impact of not having that box  
3 ticked off?

4 **A.** So it's ... yeah, it's a fair assessment. It's  
5 certainly something that could be a consent, you know, that  
6 could be ... that we could get at a later time.

7 **Q.** Would it not make sense that that would be obtained  
8 initially to streamline moving forward given that he is signing  
9 a variety of different consents at that time?

10 **A.** Yeah, you know, if we're talking about a  
11 recommendation sure, yes.

12 **Q.** Do you ...

13 **A.** I'm sure.

14 **Q.** Were you present when this authorization was signed,  
15 Dr. Murgatroyd?

16 **A.** No.

17 **Q.** No. So you're not able to say whether or not that was  
18 an intentional ... on behalf of Cpl. Desmond, that he left that  
19 off? You don't know that.

20 **A.** No, I wouldn't be able to say.

21 **Q.** Okay. And when you reviewed with him confidentiality  
22 and the releases, I think you said on June 25th when you met

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1 with him, would you have looked at the actual forms themselves  
2 or would you have just talked at a very high level about  
3 confidentiality and what that meant in terms of his care and  
4 treatment at the clinic?

5 **A.** I don't recall specifically. Sometimes we'll take out  
6 ... let me just find the page. Number 19. You know, that  
7 document specifically, 20 and ... 19 and 20.

8 **Q.** That's the ...

9 **A.** So sometimes we'll take that out.

10 **Q.** That's the Consent to Receive Services document?

11 **A.** Yeah. So that one that kind of goes over the  
12 confidentiality and limits. So on occasion I would go over that  
13 with clients.

14 **Q.** Okay.

15 **A.** I don't know if I did this specifically with Lionel,  
16 but if I didn't I would have provided a ... you know, kind of a  
17 ... I would have paraphrased it. I would have summarized that  
18 with ...

19 **Q.** Okay. Thank you. I appreciate that you didn't have  
20 Dr. Rodgers' material, but we understand from her evidence  
21 yesterday, and certainly from her material, that when she was  
22 meeting with Cpl. Desmond and shepherding him or administering

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1 the treatment one of the things she did regularly was administer  
2 a measure of depression testing, the PCL. Is that familiar to  
3 you?

4 **A.** Mmm.

5 **Q.** And is it fair to say that ...

6 **A.** Yeah.

7 **Q.** Sorry, go ahead.

8 **A.** I was just going to say yes, yeah.

9 **Q.** Okay. My understanding of your evidence today, Dr.  
10 Murgatroyd, is that throughout the course of your interactions  
11 with Dr. ... or sorry, with Cpl. Desmond, you never got into a  
12 place where you were able to start administering treatment.

13 **A.** That's right.

14 **Q.** Okay, and so I take from that that you were never in a  
15 place that you were able to measure symptoms of depression or do  
16 any testing around PTSD at all.

17 **A.** We were measuring. So one of the consents, right?  
18 The CROMIS - I think we touched on that earlier - is a ... an  
19 outcome measure that, you know, individuals will fill out when  
20 they arrive at the clinic before their session. So you kind of  
21 get a progress, and unfortunately, you know, we're not able to  
22 capture that if it's over the phone. But he would have filled

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1 that out on occasion.

2 Q. Okay, so I've not seen, to my knowledge, that type of  
3 a form that was completed by Cpl. Desmond. Is that something  
4 that would have been in the file or ...

5 A. So the forms ... they're electronic. So that's ...

6 Q. Do they still exist?

7 A. And I don't ... I wouldn't know if that could be  
8 obtained. That's a good question.

9 Q. Okay. Well, we'll work with your counsel to see if we  
10 can access those electronic measurements that were taken as you  
11 said. Not, certainly, when you talked to him by phone but when  
12 you would have seen him in person.

13 A. Sure.

14 Q. I'm going to move now from consent to some timelines  
15 and some notable milestones. We understand, of course, as  
16 you've said, the transition from being an active Canadian Forces  
17 member into being a veteran and under the Veterans Affairs  
18 system can be very challenging for members for a whole host of  
19 reason.

20 It seems from the documents, and certainly your evidence,  
21 that the transition for Cpl. Desmond from Canadian Forces into  
22 the OSI system was pretty seamless. The referral from Dr. Joshi

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1 was made three months in advance. There was an intake  
2 appointment that took place from your end in May and he had his  
3 first appointment very quickly in June. So things were well on  
4 their ...

5 **A.** Yes.

6 **Q.** ... way in terms of that. And I want to take you  
7 through a few things that I noted in your notes. It appears for  
8 me in the notes ... my friend Mr. Macdonald just took you to  
9 page 75. I want to take you back there as well. That is a note  
10 ... that is a November 9th, 2015 note that you made after being  
11 contacted by Cpl. Desmond by phone. Correct?

12 **A.** Yes.

13 **Q.** And my friend took you through that in terms of the  
14 distress that you record. You use the word "distress". You  
15 don't use the word "anger" at all in that note. Is that fair to  
16 say?

17 **A.** Mm-hmm. Mm-hmm. Yes.

18 **Q.** And there's an issue. It's a financial issue that has  
19 precipitated ... as I read this note, precipitated his call to  
20 you. Is that fair to say as well?

21 **A.** Yes.

22 **Q.** Okay, and he's worried about paying bills and feels

**DR. MATHIEU MURGATROYD, Cross-Examination by Ms. Miller**

1 ... without reading the note, but feels that there was money  
2 spent on things within the family unit that should have been  
3 used to pay bills. Is that a fair assessment?

4 **A.** Yes.

5 **Q.** Yes. Okay.

6 **A.** Yes.

7 **Q.** About two-thirds of the way down that chart note you  
8 record: "He said he has no medication at this time. He  
9 indicated he has been without medication for about a month." We  
10 know from the intake assessment - you were asked this this  
11 morning - there was a number of medications that Cpl. Desmond  
12 was prescribed, and certainly, we heard from Dr. Joshi that he  
13 was given a three-month prescription upon discharge from the  
14 military to help him transition into the new civilian world.

15 But it looks like in November of 2015 he is without any  
16 medication. I appreciate that you're not a psychiatrist and you  
17 can comment on the impact of that. We'll ask Dr. Njoku. But is  
18 that a concern for you ...

19 **A.** Mm-hmm.

20 **Q.** ... that this client has gone without medication, the  
21 numbers of medication that were articulated in the intake  
22 report? Is that a concern for you that he has been without

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1 medication for a month at this point?

2 **(17:40)**

3 **A.** Yeah, it is. It is a concern. I know that he's using  
4 the medicinal marijuana but I kind of touched on that earlier  
5 that there are concerns there as well. But absolutely.

6 **Q.** Would you expect ... would it be reasonable to expect  
7 that having no medication, prescribed medication for a month, is  
8 going to have an adverse impact on any member, and particularly  
9 Cpl. Desmond with his PTSD and major depression diagnosis?

10 **A.** I know that he noted at ... and I don't know exactly  
11 when there that he'd noted that he felt that the medication  
12 wasn't helping. But by and large I would agree to that, that,  
13 you know, an individual suffering from PTSD and Major Depressive  
14 Disorder should be on the medication that they're prescribed.

15 **Q.** Sorry, you just made a reference to him noting that  
16 the medication wasn't helping. Is that in this note?

17 **A.** Not in this one. It's just at one point - I don't  
18 know exactly where - he had mentioned that.

19 **Q.** But at this point he made no comment about the  
20 medication not helping and, in fact, I'll help orient you in  
21 terms of, I think, a little bit of context in terms of why he  
22 was without medication. If we turn to page 24 ...

**DR. MATHIEU MURGATROYD, Cross-Examination by Ms. Miller**

1       **THE COURT:**       Sorry.  Sorry, I'm going to stop you just  
2 for a minute, Ms. Miller.  So ... but I understand ... if I  
3 understand you correctly, Dr. Murgatroyd, you are agreeing that  
4 in a situation like this he should be on his prescribed meds.  
5 Am I correct?

6       **A.**       I'm not the psychiatrist or the physician, but that  
7 would be, you know, what I would, you know, be recommending,  
8 yeah, that it would be important.

9       **THE COURT:**       All right.  Thank you.  Sorry, Ms. Miller.

10      **A.**       For him to be on his medication as prescribed.

11      **THE COURT:**       As prescribed ...

12      **MS. MILLER:**       Okay.

13      **THE COURT:**       ... yeah.  Thank you.

14      **MS. MILLER:**       Dr. Murgatroyd, are you at page 24?

15      **THE COURT:**       We're still on Exhibit 244?

16      **A.**       Yes.

17      **MS. MILLER:**       Yes.

18      **THE COURT:**       Thank you.

19      **A.**       Yes.

20      **MS. MILLER:**       Okay, and this is a chart note.  I  
21 appreciate again it's not your chart note but it is in the OSI  
22 New Brunswick file.  It's from the exact same date, November

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1 9th, 2015 and under "Focus" it says, "Phone call". And then it  
2 says ... it looks like it's a note from Christy Lillington, who  
3 is a registered nurse?

4 **A.** Yes.

5 **Q.** Okay, and it says ...

6 **A.** Yes.

7 **Q.** ... "Writer received phone call from Mathieu  
8 Murgatroyd, psychologist from Fredericton OSI clinic. He stated  
9 that pat- ... client is not doing well." She then goes to  
10 review the issue about the money being abused and then she says:  
11 "Mathieu stated that the client was having trouble paying for  
12 prescriptions because of health insurance not kicked in yet."  
13 Does that help trigger your memory, Dr. Murgatroyd, about why  
14 Lionel was not taking his medication for a month in November of  
15 2015?

16 **A.** Yeah, I mean it does, you know, based on this note.

17 **Q.** And the indication as captured by this nurse is that  
18 his health insurance has not kicked in yet. So we are now five  
19 months after his release from the military. Certainly, in the  
20 military his prescriptions are covered and paid for through the  
21 military and he has access to them, as I understand, through the  
22 military pharmacy. Is that your understanding?

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1           **A.**    Yes.

2           **Q.**    And then we know Dr. Joshi had given him three months'  
3 supply to help transition into the civilian world, which would  
4 have taken us probably August/September, and now in November his  
5 health insurance has not kicked in yet. That is the health  
6 insurance that he would transition into as a member being  
7 discharged into the civilian world. Is that your understanding?

8           **A.**    Yeah.

9           **Q.**    And in your experience dealing with veterans in the  
10 OSI clinic have you ever heard of your clients and patients  
11 having difficulty with getting their medical insurance to kick  
12 in once they've entered the civilian world?

13          **A.**    It's not an issue that I recall coming up too, too  
14 much, no.

15          **Q.**    Okay.

16          **A.**    And, you know, the ... kind of the physicians and the  
17 nurses would probably be the ones kind of dealing with that a  
18 little bit more if it did pop up. If that makes sense.

19          **Q.**    Yes. Okay, but back to page 24. There's another  
20 quote ... or another piece of information, rather, attributed to  
21 you. It says: "Mathieu stated client does not have a VAC CM as  
22 well" and that, I understand, is the Veterans Affairs Canada

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1 case manager. And you talked about that earlier today ...

2 **A.** Mm-hmm.

3 **Q.** ... with Mr. Russell. So we're five months after his  
4 release from the military and he still doesn't have a case  
5 manager. Is that fair?

6 **A.** Yes.

7 **Q.** Okay. And then we know from a record at page 73 ...  
8 I'm going to take you to page 73 of that same exhibit. Are you  
9 there? This is a November ...

10 **A.** Yes.

11 **Q.** ... 19th, 2015 note. Under "Focus" it says: "Writer  
12 contacted client's CM" and this is your note, I understand, Dr.  
13 Murgatroyd. Halfway through that first paragraph it says:  
14 "Writer contacted VAC to find out if a case manager was assigned  
15 to Mr. Desmond." And then you note:

16 Writer was transferred to Ms. Marie-Paule  
17 Doucette, Mr. Desmond's newly assigned case  
18 manager. Writer gave a summary of Mr.  
19 Desmond's situation, including recent  
20 events. Ms. Doucette said she intended on  
21 contacting Mr. Desmond in the near future.

22 So you were the one who reached out to VAC to initiate and

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1 update the case manager who had been assigned at that point.

2 Correct?

3 **A.** Yes.

4 **Q.** Okay. You talked earlier about, you know, what a case  
5 manager is. You also talked a little bit about the clinical  
6 care manager, the CCM.

7 **A.** Yes.

8 **Q.** And there was a period of time, I think, through 2015  
9 where you and ... I think you had ... I don't want to misstate  
10 your evidence, Dr. Murgatroyd, but you indicated that there was  
11 some thought that perhaps Cpl. Desmond could benefit from a  
12 clinical care manager but nothing was done at that time. And  
13 the first note that I can find of an actual pointed indication  
14 of benefitting from a clinical case manager is by Dr. Njoku in  
15 May of 2016. I'm going to take you to that record and that's  
16 ...

17 **A.** Okay.

18 **Q.** ... found at page 28. Do you have that, Dr.  
19 Murgatroyd?

20 **A.** Yes.

21 **Q.** Okay, so this is a May 9th, 2016 progress note from  
22 Dr. Njoku. Toward the end of that report Dr. Njoku writes:

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1           Efforts have been doubled to speed up  
2           processing of his admission to Ste. Anne's  
3           but in the meantime he may benefit from a  
4           clinical case worker who could help him set  
5           up some structures and routines and perhaps  
6           work with him toward applying his relaxation  
7           strategies. He will continue working with  
8           Mathieu and I, and I will see him in about  
9           three weeks for review.

10           Do you have any understanding as to what, if anything, was  
11           done to action that identification of benefit from a clinical  
12           case worker at that point in time, Dr. Murgatroyd?

13           **A.** No, I'm not sure. Unfortunately, you know, if I  
14           didn't see this note kind of like in a timely fashion, you know,  
15           it ... you know, I don't want to speak for Dr. Njoku but I don't  
16           know that he would have made, you know, steps toward making that  
17           happen. It's possible, but I'm not aware of anything having  
18           been done after this entry.

19           **Q.** Okay.

20           **A.** And there's no referral that I see on the file.

21           **Q.** Okay, and that referral ... just so I understand it  
22           correctly and so all of us here do. Someone from OSI New

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1 Brunswick would have to send a referral to Veterans Affairs  
2 recommending the appointment of a clinical care worker? Is that  
3 fair?

4 **A.** Yes.

5 **Q.** That's how that would get actioned? Okay.

6 **A.** Yes.

7 **Q.** So we know from the report, the discharge report  
8 provided from Ste. Anne's ... although it didn't come to you in  
9 early October. I'm assuming that ...

10 **A.** Yes.

11 **Q.** ... as you said, you had a teleconference with them in  
12 August and various of the recommendations were reviewed. And we  
13 know from that report that there was a recommendation that a  
14 clinical care worker be appointed for Mr. ... or sorry, Cpl.  
15 Desmond. Does that ring a bell for you?

16 **(17:50)**

17 **A.** Yes.

18 **Q.** Okay, and that's ...

19 **A.** Yes.

20 **Q.** Just for the record, Your Honour, it's at page 88 of  
21 that exhibit under "Social Work Recommendations". It says: "Mr.  
22 Desmond would benefit from having a clinical care manager to

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1 help with the coordination of services, particularly given the  
2 fact that he will be transitioning to a new team."

3 I'm going to take you now ... still on the topic of  
4 clinical care manager. Or worker, I guess. I'm going to take  
5 you to page 43. And before I take you through this note. Do  
6 you understand or do you ... are you able to say, Dr.  
7 Murgatroyd, if Cpl. Desmond was advised as to what the  
8 recommendations were following that teleconference with Ste.  
9 Anne's?

10 **A.** He ... I see in this note here that he reported an  
11 interest in further testing and to assess possible brain injury.  
12 So my assumption is that they had had, you know, sort of a ...  
13 you know, gave them a set of recommendations based on that.

14 **Q.** Your assumption, sorry ...

15 **A.** But I don't ...

16 **Q.** Go ahead.

17 **A.** I don't have any recollections, yeah.

18 **Q.** Okay. That was my question. Because he ... this is a  
19 note based on phone contact that you had with Cpl. Desmond on  
20 August the 24th.

21 **A.** Mm-hmm.

22 **Q.** It looks like he had returned a phone call to you from

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1 earlier in the day, left a voicemail. He says he's reportedly  
2 doing generally well. "He indicated his new medication is  
3 helping him manage symptoms. He's living in Antigonish at his  
4 in-laws' place. At this time his living arrangement is working  
5 out ... et cetera, et cetera."

6 He then says: "Mr. Desmond reported that he was assigned a  
7 CCM in Nova Scotia." I take that to mean a clinical care  
8 manager that we've been talking about and that was certainly the  
9 recommendation in Ste. Anne's report. Correct?

10 **A.** Yes.

11 **Q.** Okay.

12 **A.** Yes.

13 **Q.** You didn't tell him that. So is that correct? He  
14 advised you of that?

15 **A.** Yes, what I see here. Yeah.

16 **Q.** So the only other place we can assume that that came  
17 from would have been a debrief at Ste. Anne's upon his  
18 discharge? Is that fair to say?

19 **A.** Yes.

20 **Q.** Okay, so he understood on August 24th that he was  
21 going to be assigned a clinical case manager. Did you know if  
22 he had actually had that person assigned at that point?

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1           **A.**    No.

2           **Q.**    Okay, and then he ... or at least you record:

3                   He (Cpl. Desmond) reported an interest in  
4                   further testing to assess a possible brain  
5                   injury, neuropsychological test and  
6                   assessment which was suggested by the staff  
7                   at Ste. Anne's. He indicated he's also  
8                   interested in doing neuro-feedback.

9                   So again, that is information that came out of the  
10                  discharge report and would have come, as you understand it, from  
11                  a debrief he received there.

12                  So at this point it sounds like Cpl. Desmond is doing well.  
13                  He's ... he understands that two key things are going to happen.  
14                  Perhaps even three. He's going to have a clinical case manager  
15                  assigned, he's going to have a neuropsychological test, and  
16                  also, he's going to be doing ... he's indicated he's interested  
17                  in neuro-feedback. I'm not sure if we know whether he's going  
18                  to do that or not.

19                  Is that fair to say that he was doing well, as he reported  
20                  to you, and was giving you an update on these things that he  
21                  understood were going to be happening?

22           **A.**    Yes.

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1           **Q.**   Okay.  Then I'm going to take you to the bottom of  
2 your note.  It says:

3                   Once again it seems like the priority for  
4                   Mr. Desmond is trying to work things out  
5                   with his family.  He's interested in having  
6                   his file transferred to Nova Scotia.  The  
7                   writer will contact his current case  
8                   manager, Ms. Doucette, to discuss his  
9                   transfer, as well as looking into community  
10                  resources.

11           I want to ask you a few things about that.  You ... I  
12 believe your evidence earlier was that the case manager was not  
13 present on that telephone conference that you had with Ste.  
14 Anne's earlier in August?

15           **A.**   I think I mentioned that I was unsure and I don't know  
16 exactly what was noted in the testimony.  So I wasn't sure.

17           **Q.**   You weren't sure.  Okay.  In any event ...

18           **A.**   Sorry.

19           **Q.**   ... on August the 24th you were going to contact her.  
20 And you say, "To discuss his transfer".  Can you give us a  
21 little bit of insight into what that meant, discussing his  
22 transfer?

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1           **A.**    I would have been referring to the inter-clinic  
2 transfer.

3           **Q.**    Okay.

4           **A.**    Or the referral over to the OSI clinic.

5           **Q.**    Okay.

6           **A.**    In Nova Scotia.

7           **Q.**    And you also indicate you're going to be looking into  
8 community resources? What would those community resources have  
9 been?

10          **A.**    I'm not sure, you know, on recollection. I don't know  
11 if I was referring here to ... because if you recall the  
12 testimony we're talking about setting him up with psychiatry at  
13 the OSI in Nova Scotia and potentially a therapist in the  
14 community. So maybe I was referring to that, and typically,  
15 it's the VAC case manager that would facilitate that or organize  
16 that.

17          **Q.**    Okay. Okay, and do you have ... I've looked through  
18 your notes. And do you know if you actually did have any  
19 communication with the case manager after August 24th, 2016, Dr.  
20 Murgatroyd?

21          **A.**    Yeah, that ... that's what I'm unsure of and it's ...  
22 it is unfortunate that I'm not seeing any other entry other than

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1 leaving the message on her voicemail in October, I believe,  
2 18th.

3       **Q.** Is it possible that you didn't contact her and if she  
4 wasn't on that teleconference debrief that you had with Ste.  
5 Anne's on August the 9th, and the report from them didn't come  
6 out till August ... or October the 6th, is it possible that she  
7 didn't have any idea what was going on from August the 9th to  
8 through when the report comes out on August ... October 6th?

9       **A.** It's possible. However, as I think I mentioned  
10 earlier, we had had previous conversation about the file  
11 eventually being transferred.

12       **Q.** Okay. And then you do transfer the file, as we know  
13 from your referral. That's September 30th, about five weeks  
14 later. That's found at page 94. The file is transferred with  
15 your referral at that point in time. Would you have needed her  
16 approval to do that?

17       **A.** No.

18       **Q.** Okay. And if we look ... and so is there any reason  
19 why that referral didn't happen until five weeks later? Like  
20 what would have been the reason for not doing it in late August  
21 or August 24th after ...

22       **A.** Yeah. Yeah.

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1           **Q.**   ... you had spoken to Cpl. Desmond?

2           **A.**   Yeah, and you know, that's something that I've been  
3 kind of wondering about myself. I think it's ... you know,  
4 there's a set of unusual circumstances, right? With, you know,  
5 an individual kind of coming out of a program like the one in  
6 Ste. Anne's but not coming back to his local team, right?  
7 Where, you know, if that would have happened, you know, it would  
8 have probably been, you know, meeting the very next week. I  
9 think I actually offered him a session.

10           And then I really don't want to put the blame on anyone,  
11 really. I don't want to put the blame on him, of course. He  
12 was returning home, right? So that was his plan, and with the  
13 treatment team over in Ste. Anne's, a delay is to be expected.  
14 So I know that I was waiting for that report and I think that  
15 played into the delay in sending the referral, thinking that if  
16 the OSI team in Halifax has that ... you know, the latest  
17 information, that, that could be useful for them. That's the  
18 thinking.

19           **Q.**   Okay. Do you recall having any communication with the  
20 VAC case manager after May of 2016, Dr. Murgatroyd? And I ask  
21 that because that's the last date I can find in your notes. It  
22 seems like you're a good note-taker. You're recording phone

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1 calls in and I'm looking at page 49. That's the last note I can  
2 find of ...

3 A. Yeah. Yeah.

4 Q. ... you communicating with the case manager, whether  
5 she calls you or you ...

6 A. Yeah.

7 Q. ... call her. So is it ...

8 A. Yeah. Yeah.

9 Q. Is it possible you had no further communication with  
10 her after May 30th, 2016, which is recorded at page 49?

11 **(18:00)**

12 A. It's possible. I would have left that message but I  
13 don't ... that might not count as communication.

14 Q. And you're referring to the message that you left with  
15 her in October of 2016.

16 A. Yes.

17 Q. When you were confirming closing Cpl. Desmond's file  
18 at the OSSI in Fredericton.

19 A. Yes.

20 Q. And just a last series of questions, and we touched on  
21 it a little bit when I first asked some questions. My friend,  
22 Mr. Russell, took you through quickly some notes ... your notes,

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1 rather, through the March/April period in 2016, leading up to  
2 Cpl. Desmond's ultimate inpatient admission at Ste. Anne's in  
3 May. And he said that ...

4 **A.** Yes.

5 **Q.** You know, he used the phrase, you know, was it fair to  
6 say that there was a rise in relationship stress during that  
7 period of time? And I think you had agreed with him.

8 **A.** Yes.

9 **Q.** And what I wanted to raise with you is to put some  
10 context around that. My read of the notes, and we can go  
11 through them, but my read of the notes, Dr. Murgatroyd, is that  
12 that relationship stress was actually tied to financial  
13 stressors. And, you know, when I read through the notes, there  
14 are certain things that jump out. We know that he had bills he  
15 was worried about paying. We know that there was an amount that  
16 he was informed he owed for taxes as a result of an H&R Block  
17 assessment. We certainly know that he had a stressor around the  
18 sale of his house in Oromocto. We also know that he was very  
19 stressed about paying for Ste. Anne's. It's evident from the  
20 notes, correct me if I'm wrong, he understood that Veterans  
21 Affairs ... he was told by Veterans Affairs that he was going to  
22 have to fund his travel to Ste. Anne's and then wait to be

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1 reimbursed. Is that correct?

2 **A.** Correct.

3 **Q.** And that caused him a lot of stress.

4 **A.** Yes.

5 **Q.** Correct?

6 **A.** Yes.

7 **Q.** And there's also, you know, we reviewed earlier the  
8 stress around being able to, or at least the difficulty of him  
9 accessing his medication because, from a financial perspective,  
10 his insurance hadn't kicked in. That's correct as well. So it  
11 seems ...

12 **A.** Yes.

13 **Q.** It seems to me that this relationship stress is  
14 grounded in these concrete financial matters. Is that a fair  
15 characterization?

16 **A.** Yeah, it came up a lot, yes.

17 **Q.** Yeah. These were not things that he was delusional  
18 about, the finances, if we accept that they were true as he  
19 recorded them to you. He had to sell his house, he had to pay  
20 to travel to Ste. Anne's. He understood that. That, in fact,  
21 precipitated you to call the case manager to ask for her to  
22 consider some financial relief for him. Correct?

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1           **A.**    Yes.

2           **Q.**    And in addition to the significant financial stress  
3 which seemed to be manifesting through that period of time,  
4 there were also some other things going on.  There was reference  
5 to him being in Fredericton for an adjudication.  Do you  
6 remember that?  And he expressed to you that he didn't sleep  
7 well the night before the adjudication and he had difficulty  
8 concentrating.  Do you remember what that was about?

9           **A.**    I saw that note, yeah.  I don't have a clear ... my  
10 memory is really not clear on what that was about, no.

11          **Q.**    Okay.  There was also reference in your notes to  
12 conflict with his in-laws?  Do you recall that?

13          **A.**    Yes.

14          **Q.**    And there was also, at least I take from my read of  
15 the notes, he was stressed about being told he wasn't going to  
16 be able to get into Ste. Anne's as quickly as he thought he  
17 would be.  Is that a fair characterization?

18          **A.**    There had been delays and so that was, you know, the  
19 referral was, we put that out, I think, in early January, right?  
20 So yes, that was a stress.

21          **Q.**    Yeah.  You had submitted the referral on December 15th  
22 and, you know ...

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1           **A.**    December, okay.

2           **Q.**    And then throughout your notes, it's recorded that  
3 there are only ten beds and you're making contact ...

4           **A.**    Yes.

5           **Q.**    ... with Ste. Anne's, but ultimately, things are  
6 expedited for him and he does get in in May, but he understands,  
7 through that period of time, there's going to be a significant  
8 delay. Correct?

9           **A.**    Yes.

10          **Q.**    And he wants to go to Ste. Anne's.

11          **A.**    Yeah, at that point, right, he was showing motivation,  
12 yes.

13          **Q.**    All right, thank you, Dr. Murgatroyd, those are all my  
14 questions. Appreciate your time.

15          **A.**    Thank you.

16          **THE COURT:**    Dr. Murgatroyd, Ms. Miller had asked you a  
17 question about Cpl. Desmond being nervous about some  
18 adjudication. Was that when he was waiting for a decision when  
19 he had appealed some level of disability, one of the disability  
20 findings? Do you recall if that was what it was in relation to?  
21 Maybe ...

22          **A.**    Was that somewhere else? Sorry.

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1       **THE COURT:**       It just occurred to me that that might've  
2 been what it was about. I don't have it directly in front of me  
3 and I was hoping that your memory would be better than my  
4 recollection of the documents.

5       **A.**     Yeah, sorry, Your Honour, I don't know if that's  
6 somewhere in the file where he was appealing, but my memory is  
7 not clear on that, and it's possible that it's elsewhere on the  
8 file.

9       **THE COURT:**       All right, thank you. Don't be concerned  
10 about it for the time being. Thank you. Mr. Rodgers?

11

12                               **CROSS-EXAMINATION BY MR. RODGERS**

13     **(18:06)**

14       **MR. RODGERS:**     Thank you, Your Honour. Dr. Murgatroyd,  
15 conscious of ... sorry. Dr. Murgatroyd, it's Adam Rodgers.

16       **A.**     Hi.

17       **Q.**     Counsel to Cpl. Lionel Desmond's personal  
18 representative. Conscious of the time and how long you were  
19 told you'd be back up on the stand and most of my questions have  
20 been asked in any event, so I won't keep you too long here.

21       **A.**     Okay.

22       **Q.**     A question to start, Dr. Murgatroyd, is can you break

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1 down, just at a high level, the relationship between yourself  
2 and Dr. Njoku in terms of treatment. Is it fair to say that he  
3 would make the diagnosis and then you would apply the ... you  
4 would conduct the treatment?

5 **A.** Yeah. I mean he ... there is a role, of course, in  
6 the treatment when it comes to the physician, when it comes to  
7 the psychiatrist. The medication is ... you know, plays a role  
8 when it comes to the stabilization to kind of get that client  
9 ready, and when it comes to the therapy, you know, portion, you  
10 know, that's where I come in.

11 Some psychiatrists, I'm not saying Dr. Njoku, but some  
12 psychiatrists have said that, you know, they're kind of adjunct,  
13 right, to be able to kind of get that client in a state - you  
14 know, I use the term "state" - in a position to be able to do  
15 the trauma focus therapy when we're talking about PTSD. So the  
16 psychiatrist plays a big role in the treatment.

17 **Q.** So trying to think of it as the psychiatrist as the  
18 coach and yourself as the quarterback. He calls the play and  
19 you put it into effect.

20 **A.** True. That could ... that's a way of looking at it.

21 **Q.** But there's a feedback that would be involved in that  
22 process as well in your therapy, and your involvement in the

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1 therapy, of course, is going to unveil certain things and you  
2 would talk to the psychiatrist about that and maybe refine the  
3 therapy or the plan accordingly. Would that be a fair ...

4 **A.** True, yeah, and he would have access to the notes.

5 **Q.** Okay. One thing that Dr. Njoku mentioned in his notes  
6 is a dissociative disorder or dissociative episodes or  
7 dissociative moments with Cpl. Desmond.

8 **A.** Mm-hmm.

9 **Q.** I take it that, in a way, you didn't get particularly  
10 far into the therapeutic relationship, but I'm wondering, in  
11 terms of PTSD treatment, if that informed the manner in which  
12 you were approaching his treatment, that idea that there may be  
13 some dissociative elements to it?

14 **A.** Yeah. And, you know, that's where the grounding comes  
15 in. That's where, you know, that's part of that stabilization  
16 work, right, if dissociation is part of the presentation, right?  
17 If the individual is experiencing, let's say, a flashback, and  
18 that's, you know, that is ... you know, sometimes we see  
19 flashbacks as being kind of associated to a dissociation, right?  
20 Well, how can we get that individual to apply some of these  
21 coping strategies such as grounding mindfulness, breathing  
22 exercises, kind of right off the bat.

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1 (18:10)

2 Q. And it seems like something that would be challenging  
3 in a PTSD context for this reason. It's noted in the DSM-V as a  
4 subtype of PTSD-dissociative episodes but ...

5 A. Mm-hmm.

6 Q. And it's for people that, they're in a situation that  
7 they can't physically escape and so they ... like a war or  
8 other, you know, a sexual assault trauma is another common  
9 example given. And so they mentally dissociate either, you  
10 know, whether it's a personal dissociation or a dissociation of  
11 place. I'll put it that way. "Derealization" I think is  
12 referred to in the material. So one of the difficulties in  
13 treatment seems to be that you would want to do normally for  
14 PTSD an exposure therapy, but if it's a dissociative PTSD, that  
15 may only exacerbate the symptoms and prolong the treatment.  
16 Well ... or undermine the treatment. Is that something that you  
17 see in your practice or you're familiar with, Dr. Murgatroyd?

18 A. You know, your point, I'm seeing. You know, I'm  
19 taking your point there. I'm not up on/clear on the research,  
20 you know, when it comes to the dissociation piece. There are  
21 myths out there, right? This idea that, you know, trauma focus  
22 therapy may retraumatize, you know, the client and set them

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Rodgers**

1 back, right? Or, you know, there are beliefs. I think they're  
2 more myths. If we're doing, you know, the therapy justice and  
3 we're kind of sticking to the structure, we are ... it's a  
4 systematic process so that, you know, the client is, you know,  
5 kind of able to be successful with, you know, situations that  
6 are more in the mild to moderate range of distress when we're  
7 talking about the exposure, if we're using the example of  
8 prolonged exposure, for example. And so he or she is able to  
9 tolerate that, and we're repeating, repeating, repeating, and  
10 then we may move on to something that is more distressing. And  
11 as we're doing that, right, we're continuing, you know,  
12 encouraging them to practice their coping strategies and their  
13 coping skills, you know, for whenever, you know, these symptoms  
14 occur, including dissociation.

15 But certainly it is a challenge and, again, you know, I'm  
16 not, you know, too, too familiar. It might be a better question  
17 for Dr. Njoku when it comes to because there can be a variety of  
18 time that elapses, right, you know, for some of this  
19 dissociation, right? So absolutely can be quite concerning. I  
20 even wonder, kind of coming back to session two, you know, there  
21 was that ... he ... for a few minutes there, he kind of checked  
22 out and I'm kind of starting to wonder if he was dissociating at

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Rodgers**

1 that point.

2 Q. Yeah. Well, I want to ask Dr. Njoku about this, but  
3 just because you were involved in the therapy, I thought I'd  
4 explore it a little bit with you ...

5 A. Yes.

6 Q. ... because in the literature, it says when the  
7 dissociative disorder is left untreated, that it can lead to  
8 such things as depression, anxiety, relationship and work  
9 problems, substance abuse problems, difficulty recovering from  
10 the original trauma, all of which, I think you would agree, were  
11 manifest in Cpl. Desmond. Would you say that you observed those  
12 symptoms in the course of your therapy?

13 A. Yes, absolutely.

14 Q. Okay. So we'll explore that with Dr. Njoku tomorrow  
15 but I want to just touch on a couple of other things. You were  
16 already asked, I guess, about the urgent referral that you made  
17 in December of 2015, and it was really six months later where  
18 Cpl. Desmond was admitted to Ste. Anne's. Do you have anything  
19 more, any other thoughts on the effect of that delay and  
20 comments, I guess? We're here as an Inquiry thinking of  
21 recommendations and here we have ...

22 A. Yes.

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Rodgers**

1           **Q.**   ... an urgent recommendation from an OSI clinic, met  
2 with six months of delay, and we're told there's only ten beds  
3 at Ste. Anne's. I guess there are others in other locations but  
4 ...

5           **A.**   Yeah.

6           **Q.**   Would you see that as an area of recommendation for  
7 treatment and transitioning of veterans?

8           **A.**   Yeah, absolutely. You know, if the funding or the  
9 resources can be put into place, right? Increase the amount of  
10 beds, right, because, again, you have individuals who, you know,  
11 the transitioning is not going well, the adjustment is not going  
12 well, the, you know, supports are not necessarily in place.  
13 They're kind of back and forth. It's probably not frequent but  
14 it happens, right?

15          **Q.**   Yeah.

16          **A.**   We're talking about individuals that, you know,  
17 they're used to moving a lot, right? And so sometimes the  
18 family might be in another location. So I'm sure it comes up.

19          **Q.**   Right. And just going ... I'm skipping around a  
20 little bit here, Dr. Murgatroyd, but in your phone call with  
21 Ste. Anne's at the time of Cpl. Desmond's discharge, you went  
22 through some of the recommendations and I'm going to come back

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Rodgers**

1 to those, but in the report itself, which I appreciate you  
2 didn't receive until two months later, there's reference from  
3 Dr. Gagnon, the psychologist, that Cpl. Desmond was having some  
4 trust issues or he seemed to be displaying some trust issues, I  
5 guess, with his treatment providers. In other words, he was  
6 questioning their motivations. And I don't know if you saw that  
7 in the report or had any thoughts on that in itself. Is that a  
8 common thing you see in patients ... veterans in particular?

9       **A.** It's certainly something that does come up. You know,  
10 I think I mentioned that even in CPT, right, where we're were  
11 ... one of the components is looking at the area of trust,  
12 right? And so it is something that sometimes comes up, right?  
13 We know that there's the guardedness, right, and as part of the  
14 presentation, we had seen some incidents of distrust. And so  
15 we're seeing it here again.

16       **Q.** And you went through, as I said, the verbal ... the  
17 recommendations over the phone in August when Cpl. Desmond was  
18 released or left Ste. Anne's and then there were recommendations  
19 made. I just want to go through a few of them with you, Dr.  
20 Murgatroyd.

21       So Dr. Gagnon had recommended a detailed neuropsychological  
22 evaluation. There was an occupational therapist that

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Rodgers**

1 recommended a neuropsychological evaluation and a functional  
2 assessment. A social worker recommended pet therapy, that Cpl.  
3 Desmond be provided with a clinical care manager, that he  
4 participate in leisure activities, like cycling, be involved in  
5 a yoga class, recommendation for art therapy, recommendation  
6 that he see an addictions counsellor. There was a  
7 recommendation from his osteotherapist that he get involved in  
8 nordic walking and training in a gym under supervision of a  
9 trainer.

10 From what we can glean so far, Dr. Murgatroyd, it seems  
11 that none of those recommendations made in August came to  
12 fruition. I'm not suggesting it's your responsibility, but what  
13 I want to ask is, you know, knowing that now, I mean you  
14 obviously had some concern about Cpl. Desmond. You called to  
15 check in on him. You mentioned earlier that you were acting at  
16 a time, or felt you were acting as his clinical care manager. I  
17 mean what's your reaction to hearing that none of those  
18 recommendations were put in place over the months following his  
19 release from Ste. Anne's?

20 **A.** Right. You know, it's ... certainly here, you've got  
21 a group of ... and it's a multidisciplinary program with a lot  
22 of resources and going from that to rural Nova Scotia. And

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1 again, as I think I mentioned earlier, just these unusual  
2 circumstances of him kind of going from one clinic to the next,  
3 there's going to be these ... you know, due to these unusual  
4 circumstances, there are going to kind of be delays built into  
5 that, if you know what I mean.

6 **(18:20)**

7 **Q.** Sure.

8 **A.** Just because of that decision to kind of move to Nova  
9 Scotia. And so be that as it may, you know, some of these  
10 resources might not be available just because, you know, of the  
11 resources in the community.

12 **Q.** Sure.

13 **A.** So that is a challenge, certainly.

14 **Q.** Thinking of it less maybe from a bureaucratic point of  
15 view but more of a therapeutic point of view, Dr. Murgatroyd,  
16 would you say that, you know, this multidisciplinary team that's  
17 made these recommendations, which seem, on their face, to be  
18 well applicable to Cpl. Desmond and, you know, here months go by  
19 and ... first of all, months go by and nobody really knows about  
20 them, it seems, perhaps, and then none of them get implemented.

21 **A.** Mm-hmm.

22 **Q.** From a therapeutic point of view, I guess, would you

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Rodgers**

1 see that as a significant problem?

2 **A.** It's a concern, yes.

3 **Q.** All right. Thank you, Dr. Murgatroyd, those are my  
4 questions.

5 **A.** Thanks.

6 **Q.** Thank you.

7 **THE COURT:** Mr. Rogers?

8

9

**CROSS-EXAMINATION BY MR. ROGERS**

10 **(18:22)**

11 **MR. ROGERS:** Thank you, Dr. Murgatroyd. You'll be  
12 pleased to know my questions should be probably no more than  
13 five minutes. I'm Rory Rogers and I'm counsel for the Nova  
14 Scotia Health Authority.

15 Could you turn, please, first to page 76 of the New  
16 Brunswick Horizon record exhibit we've been looking at? This is  
17 an entry that you referred to earlier and it's dated October 23,  
18 2015, and at the bottom of this entry it states that: "In terms  
19 of follow-up treatment, Mr. Desmond said he'd be open to  
20 traveling to Halifax since it's a shorter distance. I told him  
21 that we would be transferring his file over to the OSI clinic in  
22 Halifax. I told him he could expect a call from the Halifax

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Rogers**

1 clinic in the coming weeks." And then if we go back to the  
2 previous page, page 75 of the same Horizon record, we see  
3 another reference to what's referred to as the OSI clinic in  
4 Halifax, and at the bottom of that page, the bottom entry from  
5 November 9, 2015 ... you can scroll down a bit. Thanks. That  
6 states, "Writer ..." - and this again would be your note - it  
7 says: "Writer contacted Christine Lillington, nurse at the OSI  
8 clinic in Halifax. Ms. Lillington said she had attempted to  
9 contact Mr. Desmond in late October/early November without  
10 success. He had not returned her call." And I know you touched  
11 on this, but I just wanted to make sure it's clear. Am I  
12 correct, Dr. Murgatroyd, that in 2015, there was, in fact, no  
13 stand-alone Nova Scotia OSI clinic?

14 **A.** Yeah, that's correct.

15 **Q.** And that what existed at that time in Halifax and in  
16 Nova Scotia was a satellite clinic of your New Brunswick OSI  
17 clinic. Correct?

18 **A.** Yes, yes.

19 **Q.** So the reference to Ms. Lillington here, a nurse at  
20 the OSI clinic - and I think you mentioned in your testimony  
21 earlier today that there were also psychologists - they were, in  
22 fact, either independent contractors or employees of the New

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Rogers**

1 Brunswick OSI clinic or Horizon. Correct?

2 **A.** Yes.

3 **Q.** And I think the Inquiry will hear evidence from  
4 witnesses at the Nova Scotia OSI clinic, now the stand-alone  
5 clinic, who will indicate that the Nova Scotia clinic started  
6 operating in Dartmouth in 2016. Is that your understanding as  
7 well?

8 **A.** Yes.

9 **Q.** Fair enough, but in 2015, there was no separate Nova  
10 Scotia OSI clinic. It was really all a part of the New  
11 Brunswick clinic. Fair?

12 **A.** Yes.

13 **Q.** Okay. The only other area I want to touch on - and  
14 I'll try not to replot the field others have - is the question  
15 of access to records which has come up in a number of contexts  
16 through your evidence and through evidence of others at this  
17 Inquiry.

18 So I understand from your evidence given earlier today that  
19 when the referral came in to the New Brunswick OSI clinic, that  
20 some 57 pages of documents were provided with the referral that  
21 are found at pages 100 to 157 of the record that you have, that  
22 you referred to earlier. Is that correct?

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Rogers**

1           **A.**    Yes.

2           **Q.**    And those are psychiatric assessments and psychiatric  
3 progress notes of Canadian Armed Forces.    Correct?

4           **A.**    Yes.

5           **Q.**    So that when you were asked to undertake your own  
6 assessment and provide care to Cpl. Desmond, that was part of  
7 the OSI New Brunswick chart that you had available as part of  
8 your assessment and care.    Correct?

9           **A.**    Yes.

10          **Q.**    And you would've also had the triage or intake  
11 materials that were done by nursing staff at the Fredericton OSI  
12 clinic and you would've had available the information that Cpl.  
13 Desmond was providing to you.    Correct?

14          **A.**    Yes.

15          **Q.**    And so those were the pieces of information you had  
16 that you wanted to use as part of your assessment and your care  
17 for Cpl. Desmond.    Fair?

18          **A.**    Yes.

19          **Q.**    Would I be correct, Dr. Murgatroyd, in assuming that  
20 you, as a clinician, would also determine in any case, and in  
21 Cpl. Desmond's case, whether there are additional medical  
22 records that may be available, that may be of assistance, to you

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Rogers**

1 as part of your assessment and care?

2 **A.** Yes, that can be part of it, yes.

3 **Q.** And so you, as a clinician, or I guess a psychiatrist  
4 or physician, would, in each case, ascertain whether there are  
5 additional records that can be important to track down and make  
6 part of your review. Fair?

7 **A.** Yes.

8 **Q.** Now, in this case, and I guess in any case, I'm  
9 assuming there are a number of ways that those additional  
10 records could be made if a clinician determines that they may be  
11 important. So I'm assuming ... because I've seen some cases  
12 where patients have a copy of some of their own medical records  
13 that they provide to a new clinician. Have you seen that case?

14 **A.** Yes, that can happen, yes.

15 **Q.** So the patient could have records they could bring  
16 with you and that could provide the material that you, as a  
17 clinician, would think important or necessary. Fair?

18 **A.** Sure, yes.

19 **Q.** And I'm thinking a second situation is that you, as  
20 the clinician, could ask your patient on their own to locate and  
21 assemble and provide to you the records that you, as a  
22 clinician, feel might be appropriate. Is that a second option

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Rogers**

1 that you've seen?

2 **A.** I imagine that would be a possibility, yes.

3 **Q.** Now, if that were the case, would it be your practice  
4 to then make an independent assessment as a clinician as to  
5 whether your patient has the capacity and ability on their own  
6 to be securing those records?

7 **A.** Sort of assessing, you know, the patient's ability to  
8 go and do that independently, you mean?

9 **Q.** Yes.

10 **A.** Yeah, sure. Kind of assessing that that would be my  
11 responsibility, yes.

12 **Q.** Okay. And then as I think through the options of  
13 getting those types of records, again, if a clinician determines  
14 they are relevant, the third option would be to secure some form  
15 of consent that would enable you or your clinic or the  
16 psychiatrist or the physician to then take steps to get those  
17 records directly. Correct?

18 **A.** Yes.

19 **Q.** And so as I work through what the options are there,  
20 you, as the New Brunswick OSI clinic, are clearly dealing with  
21 referrals in, for the most part, from CAF and from the RCMP.  
22 Correct?

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Rogers**

1           **A.**    Yes, and Veterans Affairs.

2           **Q.**    Right.  And so is there an ability for you to be  
3 asking for records from VAC, Veterans Affairs, or CAF, Canadian  
4 Armed Forces, without getting consent from the patient, or do  
5 you need to get consent from the patient if you're getting those  
6 records from VAC or CAF?

7    **(18:30)**

8           **A.**    I believe you would have to get the consent from the  
9 patient.

10          **Q.**    Okay.

11          **A.**    That's my understanding.

12          **Q.**    And I'll come back to that in a moment.  But I guess  
13 the other source of information that I can think of of potential  
14 health records that could be relevant, is if you're looking for  
15 materials that are outside the CAF or VAC world and they might  
16 be available from a provincial health record or a family  
17 physician or ...

18          **A.**    Right.

19          **Q.**    ... a healthcare provider in the community, correct?

20          **A.**    Right.  Yes.

21          **Q.**    And, again, have there been cases where you, as a  
22 clinician, have determined that those records are relevant and

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Rogers**

1 steps should be taken to secure those records?

2 **A.** I don't recall having done that, no, but ... to my  
3 recollection. But it would be possible, right, if let's say,  
4 you know, an individual has been seen in ... as with ... by the  
5 psychologist, right, is requesting that information, yes.

6 **Q.** Fair. And the process does exist to get those types  
7 of materials. As we see from your own records if we go to page  
8 17 of the Horizon record ...

9 **A.** Yes.

10 **Q.** ... this is the release ... This is the Horizon OSI  
11 clinic release of information record that you looked at and  
12 commented earlier because it was ...

13 **A.** Yes.

14 **Q.** ... talking about Cpl. Desmond originally authorizing  
15 information to be provided with ... to Shanna Desmond, which he  
16 subsequently rescinded, correct?

17 **A.** Yes.

18 **Q.** But as I look at that form, it is also a form that  
19 would allow the OSI clinic to secure authorization from a  
20 patient to get information from any other source, including  
21 those that I just mentioned, correct?

22 **A.** Yes.

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Rogers**

1           **Q.**    So if you made the determination, for example, that  
2 the health records of the Chalmers Hospital where you had been  
3 advised Cpl. Desmond went as a result of an issue or crisis I  
4 think in November 2015, you could have secured consent from Cpl.  
5 Desmond to get those health records with this form, correct?

6           **A.**    Right.

7           **Q.**    But the key, of course, on all those occasions is that  
8 you have to get consent from your patient in order to get those  
9 records, correct?

10          **A.**    Correct.

11          **Q.**    So am I right then that the three steps in getting  
12 that kind of health information to allow you or allow any  
13 physician or allow any psychiatrists or any healthcare provider  
14 to access those records to use as part of the assessment and  
15 care, is first step is that the clinician would need to  
16 determine if other records are potentially relevant, correct?

17          **A.**    Yes.

18          **Q.**    And then the second step is that if the patient didn't  
19 provide them directly you would need to get consent from your  
20 patient for release of those records, correct?

21          **A.**    Yes.

22          **Q.**    And those are really steps that are clinician-driven,

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Rogers**

1 clinician in terms of psychologist or psychiatrist or physician,  
2 correct?

3 **A.** Yeah, or other health professionals, sure.

4 **Q.** Fair. And then the third step that I think is the  
5 last step is really the administrative steps of then taking that  
6 consent from a patient and getting those records. And I'm  
7 guessing that's something that would not be something that you  
8 would typically be doing but you'd be handing off to somebody in  
9 the administration within your facility, correct?

10 **A.** Yes. Yes.

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

12 **A.** I should mention, again, I touched on that earlier,  
13 just the differences in systems, right, within, you know, the  
14 corporation, you know, for example, Horizon, right. So there is  
15 kind of like that element.

16 You know, if I'm getting a referral from a physician, you  
17 know, I typically ... you know, this physician is through  
18 Horizon, I'm able to kind of have that communication, right.

19 The OSI clinic is a Horizon ... you know, it is under  
20 Horizon, right, but the ... one of the issues is that it's a  
21 different data entry system, right. So I ... even though we're  
22 the same, you know, corporation, Horizon, I can't just kind of

**DR. MATHIEU MURGATROYD, Cross-Examination by Mr. Rogers**

1 jump on the computer and see, you know, what happened at the  
2 deck even if, you know, we're kind of internal, right.

3 And so that may be ... you know, that may be something  
4 worth exploring with management, you know, rather than myself in  
5 terms of, you know, maybe where changes ... if you're looking  
6 for recommendations where changes could be made.

7 **Q.** Fair enough. But I guess in that scenario, even if  
8 you don't feel for privacy reasons you could access part of a  
9 patient's record that's been created elsewhere, you do have the  
10 ability to go to the patient and seek their consent so you can  
11 get access to those materials, correct?

12 **A.** Yes. Yes, that's still relevant. Yeah.

13 **Q.** Okay. Thank you.

14 **A.** Thanks.

15 **THE COURT:** Mr. Hayne?

16 **MR. HAYNE:** Thank you, Your Honour. I have no questions  
17 for this witness.

18 **THE COURT:** Thank you. Mr. Mackenzie? Oh sorry, you're  
19 with Mr. Rogers. Sorry.

20

21

22

**DR. MATHIEU MURGATROYD, Examination by the Court****EXAMINATION BY THE COURT**1  
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22**(18:37)****THE COURT:**

I have just one question for Dr.

Murgatroyd and there's been a lot of discussion about records and access to records, and in my view a lot of it centers around the fact that the therapeutic records, that is, the records that were kept by Dr. Rogers in relation to her therapeutic interventions with Cpl. Desmond were not sent over as part of the package of documents from CAF.

And we know that Dr. Rogers completed her therapy with Cpl. Desmond. I have a document, it's Exhibit 222, and it's just dated February 19th, 2013. I appreciate it wasn't sent over and I appreciate that it wasn't really pursued but, Dr. Mergatroyd, can you see any set of circumstances where documents, that is the entire kind of therapeutic record of Dr. Rogers, would have absolutely no value to you at all and it would be just a waste of time to both reading it?

**A.** No, I ... you know, I think it ... that that would be valuable information. I don't think ...

**Q.** Yeah, sure, I asked you a question, I think the answer is pretty self-evident, but I leave it to you because it really is a decision that you make, is it not, as to whether or not

**DR. MATHIEU MURGATROYD, Examination by the Court**

1 you're going to pursue it and think it might be of some value in  
2 your treatment of Cpl. Desmond. Do I have that correct?

3 **A.** Yes, Your Honour.

4 **Q.** Right. So I have one other question and it's really a  
5 question that's going to be directed towards Mr. Canty because I  
6 want to ask him a question first.

7 If I ask Dr. Murgatroyd as to whether or not he was  
8 involved in any kind of any internal review of his practices or  
9 that of the clinic after the events involving Cpl. Desmond, is  
10 that a question that he's going to be able to answer or is there  
11 going to be any legal barrier to it?

12 **MR. CANTY:** Your Honour, I think I would not object to  
13 the question as long as ... you have in my letter which outlines  
14 that we're not really willing to provide a copy of any  
15 conclusions.

16 **THE COURT:** Okay.

17 **MR. CANTY:** But if you ask him if he's been involved,  
18 that's fine. And you also have my comments concerning any kind  
19 of recommendations made by that review.

20 If you're going to ask him about whether he participated, I  
21 would have no objection.

22 **THE COURT:** All right. Well, that's a short road

**DR. MATHIEU MURGATROYD, Examination by the Court**

1 leading nowhere. So what I will do is I'll just let the  
2 question go for now and thank you for your comments in that  
3 letter, Mr. Canty.

4 And, Dr. Murgatroyd, I'd like to thank you, sir, for your  
5 time. I know that some effort had gone into having discussions  
6 and interviews with counsel and going over documents in advance  
7 of today's date, and I can appreciate it's not ... may not  
8 always be pleasant to sit there and answer a lot of questions  
9 and review circumstances that are on many difficult levels  
10 difficult, so we'd like to thank you. I would like to thank you  
11 for time and for your consideration in providing us with the  
12 information today. Thank you.

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

14 **THE COURT:** Thank you, Mr. Canty, as well.

15 **A.** I'm glad I was able to participate. Thank you.

16 **WITNESS WITHDREW (18:41 hrs.)**

17 **THE COURT:** All right. Thank you. Thank you, Counsel,  
18 we'll adjourn for the day. We'll be back tomorrow morning at  
19 9:30. Thank you.

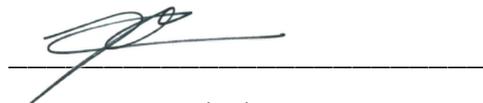
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21 **COURT CLOSED (18:41 HRS.)**

22

**CERTIFICATE OF COURT TRANSCRIBER**

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



Margaret Livingstone

(Registration No. 2006-16)

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**DARTMOUTH, NOVA SCOTIA**

**March 5, 2021**