CANADA

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF THE

FATALITY INVESTIGATIONS ACT

S.N.S. 2001, c. 31

THE DESMOND FATALITY INQUIRY

TRANSCRIPT

HEARD BEFORE: The Honourable Judge Warren K. Zimmer

PLACE HEARD: Port Hawkesbury, Nova Scotia

DATE HEARD: March 4, 2021

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KAMA HAMILTON

EXHIBIT LIST

March 4, 2021

COURT OPENED (09:31 HRS)

THE COURT: Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Ms. Hamilton?

A. Yes, hi.

THE COURT: Good morning.

A. Morning, Your Honour.

THE COURT: Just before we begin, Ms. Hamilton, we would typically either have you sworn or make a solemn declaration to tell the truth, and the Clerk will give you some options here.

A. Okay, thank you.

KAMA HAMILTON, affirmed, testified:

THE COURT: Again, good morning, Ms. Hamilton. I understand you have counsel with you?

A. Yes, I do, Your Honour.

Q. All right then, thank you, and welcome, Counsel.

MR. CHABOT: Good morning.

THE COURT: Ms. Hamilton, if, during the course of the morning, we happen to lose connection, either of the audio or video, just bear with us. If you have difficulty from your end with regard to either, perhaps just let us know. We have some ability to troubleshoot from our end as well.

I think that Mr. Russell will lead off the questioning this morning. Thank you. Mr. Russell?

DIRECT EXAMINATION

MR. RUSSELL: Good morning, Ms. Hamilton.

A. Good morning, Mr. Russell.

Q. I'm wondering if you could state your full name for the Court?

A. Kama Hamilton.

Q. And Ms. Hamilton, I understand that you are a social worker.

A. Yes, I am.

Q. What I'm going to do, I guess, is we're going to outline a little bit of your qualifications first before we get into the actual evidence. Do you have in front of you ... we'll put it on the screen. It's Exhibit 246. It's a copy of your *CV*.

EXHIBIT P-000246 - *CURRICULUM VITAE* OF KAMA HAMILTON

A. Yes, I do.

Q. So when did you graduate with your Bachelor of Social Work?

A. A while ago. It was June 2004.

Q. And where did you get your degree?

A. At McGill University.

Q. So I guess before we get into your employment history, on the second page, it says, "Other Training". I wonder if you could just tell us generally, some of the areas in which you've received training and if you apply them in your day-to-day practice.

A. Yes. Since coming to Ste. Anne, it was ... I took different trainings in post-traumatic stress disorder to better

understand it. I also followed some cognitive behavioural therapy. The CBT I cannot apply in an official sense in my work because it requires a psychotherapy permit in Quebec to be able to do that. However, it does inform some of what I do, the concepts of CBT.

Motivational interviewing I also did, which is a type of, it's a therapeutic approach where you, rather than giving your client advice, you help them to come up with their own plan. The social work interventions for trauma was another one that I did and I haven't applied that as much in my work. It's really quite similar to the other trainings that I had done. Suicide prevention is something that we do (inaudible - audio). We always have that in the back of our mind to keep our eyes open and our ears open for any signs that someone may be considering suicide. So that definitely is a part of what we do. And systems-based family intervention is also another training I did, and that helps me to work with a person and include the system, the family system, that they're in and figure out what is going on there and how we can help in that area.

Q. If you could tell me a little bit more about symptoms-based family intervention. What does that involve? Could you give us some examples?

A. Well, systems-based family intervention, it's really about looking, when you're treating a person, you're trying to help a person, if you want to help them in their family interactions, you need to understand how the family dynamic functions. Their difficulties don't function in an island. There's an impact and there's an interaction with the family.

So what we often talk about in our groups or in individual sessions is that when a person has been away from their family and then they return home, during their absence, the family has formed a unit without them. And so when they come back in, it's like the puzzle pieces have to readjust and change shape and modify their roles so as to make space for the individual who's been absent. So this is relevant for them when they have gone on missions and gone back home again, but it's also relevant when they've gone away and spent three months with us in our program, is trying to find where they fit in, how can they enter that dynamic. So understanding the family dynamic is important.

Q. So when you're at Ste. Anne's, and we'll get into your employment history a little bit, but when you're at Ste. Anne's and you are treating a veteran, systems family intervention is something that you kind of have at the forefront of your considerations?

A. It's often there. It depends on the person's needs. For some people, they come in and their family situation is quite healthy, so it's really we're more focussed on their own personal goals. And for other people, it's really we do more with the family. But either way, it's a discussion that I always have with them when they return home is be prepared for the fact that during their absence, this family unit has been created and it can take a little bit of time to fit back into it.

Q. Sort of being mindful of bridging that gap between military service and returning, sort of, to civilian life and family outside of the military?

A. Yes, that and, well, there's in a smaller sense, just within the family household. Who's going to take the kids to the day care? Who's going to make the meals? There's that dynamic there in a smaller sense. And then yes, in a greater sense, the transition to civilian life. That's much a bigger job.

Q. And is that something that you frequently encounter where a veteran finds they're struggling to sort of find where they fit in the picture of where they last left off with their family?

A. It often is and it's partly because of the absences, and if they've been on multiple missions, then each time they go away, the family has to adapt without them being there. And then it's complicated by the fact that if they come back and they develop symptoms, then many times those symptoms will lead them to isolate and to not be able to function, not be able to participate fully as a father or as a husband or wife or et cetera. So, yeah, it's something that we have to consider.

Q. So I'm wondering if we could turn briefly to your employment history.

A. Mm-hmm.

Q. But without reviewing it all. So my understanding is from 2016 to present, you have been employed at the Ste. Anne's clinic in Quebec?

A. Yes.

Q. So if you could basically outline for us, what is your role as a social worker in that Ste. Anne's clinic structure since 2016?

A. As a social worker, I see all of the residents from the time they arrive and I work with them in groups and in individual settings. The groups that I animate are anger management group and social networking, and I can get into those

later if you like. And then I do individual service where we do ... I look at their social functioning, how they're doing at home, and (inaudible - audio) their lives and we try to identify collaboratively what are the areas that they would like to work on while they're in the program. And it usually revolves around their social functioning. So their relationships with their family, their social network. Yeah, overall, how they're doing in their home environment.

(09:40)

Q. We've learned quite a bit about the stabilization phase and the residential phase of the Ste. Anne's program. Your role as the social worker, are you involved in both phases?

A. Yes. Yes, I am.

Q. And does your role in the stabilization phase differ from your role as a social worker in the residential phase?

A. No. When someone first comes, I'll see them more individually. They don't have as many groups. But the role that I play doesn't change. They just, in residential, I animate one group and ... not residential, sorry. In stabilization, I have a group, and in residential, it's a different group.

Q. And you indicated that there were two types of group

therapy that you sort of oversee and I wonder if you can indicate what they are and what they involve.

A. Sure. The first one is in the stabilization phase and it's called "social networking". And the overall purpose of that group has been to, first of all, identify the fact that many, many veterans or people suffering from PTSD are isolated and it's a natural tendency that when we're not well, we don't want to go out because of the hypervigilance and so on. However, there's also been a lot of research supporting that social connections is a major part of getting well. It has a big effect on your well-being, both with physical recovery and with recovery from mental health difficulties.

So I do some psychoeducation there on the importance of having a social network. Not necessarily (a group?) to him but having the sense that there are people around you who support you. And then we look at what makes it difficult for you to have that? What ... you know, we talk about the hypervigilance and the difficulty trusting and the difficulty with the transition to civilian culture. We identify what all those barriers are and then we go about trying to, you know, so how could you get past those barriers? Knowing how important it is to have these social connections, what could you do to make it

easier to start forming them?

Q. Okay.

A. So that's the social networking bit. The other group that I do is anger management. It's a program that was developed by a psychologist at Ste. Anne many years ago with veterans, so it's specific to veterans. A program called PEACE. Program for experiencing anger with control and effectiveness. The idea behind that is ...

Q. Sorry to cut you off there. So the program was called, did you say "PEACE"?

A. PEACE, as in, like ...

Q. And I'm wondering ... so I guess ... and does it stand ... what does it stand for?

A. It stands for the program for experiencing anger with control and effectiveness.

Q. Okay. And tell us a little bit about the goals behind that program and what does it involve?

A. So that program is really ... it's exactly what it says. Helping the veterans ... because anger management is a very, very common difficulty for people ... for veterans, in particular, with PTSD. So helping them to find strategies to, in a nutshell, to find space between the input or the incident

and your reaction. So anytime something happens, instead of reacting immediately, to find that space in between to figure out how they want to react in a controlled and effective way. And that space can be found through relaxation, it can be found through cognitive exercises of trying to think of things in different ways rather than, you know, jump to conclusions. We talk about different types of thinking that might lead you to jump to conclusions or lead you to see things in a more black and white manner and how you can gradually add more flexibility into that way of thinking so as to have more choices in how you react.

Q. So are there any ... you've outlined two primary types of group therapy that you're involved in administering at Ste. Anne's. Are there any other types of group therapy that you, as a social worker, are involved in at Ste. Anne's?

A. More ... yeah, more recently, I was doing what we call the stop and go group, which is basically a goal-setting group that we meet with them twice a week for people to identify objectives. I wasn't doing it at the time that Lionel Desmond was with us, but I have since become involved in that group where the idea is just to help people break down their objectives into smaller, attainable goals.

Q. We talked a bit with other witnesses about individual psychotherapy and individual ... other types of therapy, cognitive behavioural therapy, prolonged exposure therapy. What is it about group therapy and someone, say, like Lionel Desmond or other veterans, what is the value in having group therapy as supplementing individual therapy? I'm assuming there's some value because you're doing it.

A. I believe. I believe there is, yes. Group therapy ... and often, I think it's helpful for everyone. However, with veterans, it's even, I believe, even more helpful because they have been isolated for such a long time and because they often have great ... high levels of shame about suffering from PTSD and there's a lot of stigma within the military culture, from what the veterans have told me, about having PTSD. They call it the "walk of shame" if they have to go to see the psychologist when they're on the base.

So all that to say that when they're in a group with their peers, if other people that they see as strong and functioning and intelligent, and those people are sharing the same difficulties, saying, Yeah, me too, I can't go to the grocery store without my heart racing and without my ... you know, breaking into a sweat. So that, in and of itself just alone,

seeing they're not alone, it's usually beneficial.

On top of that, some ... you know, we have people from all different walks of life. So they may have been retired from the military for many years or they may be just in the process of starting. So the people who practice many different strategies can share the things that work for them and they can talk about, Well, yeah, I used to be like that but I started doing this and it really helped. So there's a lot of sharing of information and of experiences that occurs that help them.

For me, the best group is when I barely say a word. I introduce the topic, I explain the principles, and then they share and they discuss and all I do is guide and it's very, very helpful.

Q. So you see a strong benefit in that shared sort of experience, shared understanding of what each other are going through?

A. Yes.

Q. I'm going to veer off course. I wasn't going to get into this until much later, but this concept of group therapy and sort of the comfort that maybe a veteran takes in a common understanding, from a social worker perspective, how does culture play into that? Are you able to say you observed sort

of a shared experience from understanding a background? For example, in Lionel Desmond's case, he's African Nova Scotian, and an understanding of being able to confide in others that really have a sense of understanding where he came from, what traumas he might've experienced, just by the fact of his race. Is there anything you can add in what you've seen?

A. In what I've seen, I find that with active military members and with veterans, the primary culture is the military culture and that is what brings them together. I haven't ... just having observed, I've never observed any difficulties in terms of cultural differences.

Sometimes within the military, a reservist versus a reg. force, there may be some posturing, but really that's one of the things that makes people enjoy the military so much is that they have this shared culture. There is a homogeneity. So whether you're black or white or regardless of where you come from, once you've done the training, you're military and that's your culture and that's ... you follow the same rules, you have the same values. It's a very cohesive type of unit.

Q. I don't want to get too hypothetical, but I'm going to unless the Judge stops me. So we've heard evidence earlier on in different testimony that Lionel Desmond had experienced

racism in the military, and other members of the military, from his background as a black man, experienced racism. And it led to sort of, although they felt connected, they felt very different in many ways. Do you have any comments about how that can play into treatment?

A. I can't really comment on it. It's not something I ever observed. Or maybe it's something that I missed. It's not something that Lionel Desmond ever brought up with me, that feeling, that sense of disconnection due to race. He told me that he chose to keep to himself often when he was in the military but he didn't mention that it was connected to his race in any way.

Q. Okay. To your knowledge, is it something that has been explored from a social worker aspect?

A. It wasn't explored with me. It wasn't something that came up in any of our conversations.

Q. Okay. I'm going to ask you a series of questions that we've been asking psychologists and psychiatrists just to sort of get a general understanding of perhaps if there's a difference between treating active members of the military and military veterans versus members of the civilian population.

(09:50)

So I'll take you through four things and if you could sort of articulate if there was any challenges or barriers that ... or identifiable issues that you see when treating members of the military. I guess first dealing with building a therapeutic alliance. How might that be different with a member of the military or retired member of the military versus someone in the civilian population?

A. It is different. I mean you use the same strategy, however, it is different. I think that because of that insular military culture that is part of what makes it so strong, there can be a distrust of civilians, of outsiders. So when you meet with a veteran, it's not ... whereas when I've had other clients who were not in the military. It's fairly easy and quick to establish trust. I sort of walked in and they already trust ... they trust me because of my position, because I'm a social worker, because they just assume that I'm trustworthy.

With veterans, there's no assumption. You have to earn the trust. You have to work with them to show that you are trustworthy. And so it takes a little bit longer. But it's ... with most people, that therapeutic alliance can be created. It just ... you know, you have to be aware that there are differences. You can't be late for your meetings. You have to

try to keep in mind the expectations that come from being a military member.

Q. And the exact same question about challenges, barriers, that might be unique to a military-based population versus civilian in identifying treatment goals.

A. That, actually, I don't know that there would be a great deal of difference. With identifying treatment goals, generally, once we've gone through the social functioning evaluation and my other colleagues go through their evaluations, we're usually able to, with the client, pick out the areas that they want to work on. Some people arrive with really no idea and they just say, Well, my life is just not working. I need something to change. And it might take a few weeks to get to the point where we're able to pick out what those specific areas are, but most of them have ... I mean they're pretty action-oriented. They have ideas of where they want to go and how they want to get there.

Q. What about in the implementation or the process of treatment? Do you see any challenges, barriers, or identifiable issues to be mindful of when it comes to treating members of the military?

A. I think the most important thing really is

understanding military culture and, yeah, just understanding those things. The timings are very important. Being there on time. Also allowing ... there's a lot of ... they're very respectful and they expect to be treated with respect. So there's a mutual respect with us. I think that's similar to any therapeutic relationship though. But in the process of treatment specific to veterans? No, I don't see that it's significantly different other than always keeping in mind the military culture and respecting that.

Q. So there is value in the clinician having an understanding of the military culture prior to, I guess, going into first session even.

A. I believe so, yes, yeah.

Q. What about the same question in terms of the continuity of care or the follow-up in the handoff from, say, a residential program like Ste. Anne's to a community structure? What are things to be mindful of with a military-based client?

A. Specific to military, I can say, in our program, I would say it is ... because it is highly structured, we have programming from Monday to Friday. One of the reasons that I think that it works well for some people, they've been removed from their everyday stressors. So all of the things involved

with living at home - getting your groceries, planning your meals. All those things have been removed so they're able to focus exclusively on their treatment.

So when they're transitioning you have to keep in mind, first of all, that there's going to be less structure. They can't ... they won't be able to create the same amount of structure at home as they have in a program. Nor would we want them to but I can get into that later. So they can't create that same amount of structure and they also don't have the same amount of social contact as they had with their peers. And, again, that's where the military culture comes in. That social contact is very important and one of the things many people discuss is sort of a grieving process when they have left the military of I don't feel like I belong to anything anymore. I was military, you feel like you're a part of something bigger than yourself. When they leave, they really leave and they have ... they don't ... often are very isolated. They don't have that sense of belonging. In our program, they regain that sense of belonging with their peers and then they leave it again.

So these are all things, when we're planning a transition, that we will find (inaudible - audio) do you have enough planned in your week? Even if it's two to three appointments a week.

Not necessarily therapeutic appointments, but sports, leisure, friends. And let's try to make sure you've got some social connections that you can revisit to prepare for being at home.

Q. So can that transition be ... I guess everyone is different, obviously, but can that transition be quite stark for a veteran who has been discharged from the military, whether it's six months or four years, that transition between a close connection and a feeling of belonging with a group to, I'm now sort of cut off from what I've known?

A. I think it's, like you said, it's different for everybody because some ... it's a difficult transition no matter what. However, some people are going back home to their families to ... they have friends, they have people they see. It's a familiar space, a familiar environment. So it's not quite as stark. And they maintain a continuity of, you know, they have their appointments that they've set up before they leave. So they ... it's not as stark for them. It's still a big change, but they're ... it's less.

For other people ... I mean if we talk specifically about Lionel Desmond, in his case, it was a lot of change all at once to go from ... to a new province, a new house with a new living situation. It would've been quite a significant change.

Q. And you had noted in your report, and we'll get to exactly where, but you talked that he seemed to ... he identified very sort of few close friends or close connections and he is returning sort of to a relatively rural area. Was that transition, did that seem to be having an impact on him?

A. I think towards the end, there were a variety of stressors that had been having an impact. The selling of his home, to begin with, was an impact. Trying to work out with his wife how they were going to reconcile was having its impact. He also had, you know, as you know in the notes, had some conflict with one of the staff which also had its impact. And most people, in the last couple of weeks before they leave, their anxiety does go up as they plan for this departure but, yeah, I think that anticipating all of these changes was making him more anxious and overwhelmed to some extent.

Q. I'm going to get this wrong and I can't remember where I sort of got it, but they talk about sort of major life stressors, you know, for example, a new baby, divorce, those sort of ... loss of employment. In Lionel Desmond's case, while he was at Ste. Anne's and sort of making that transition back home, did he have a number of identifiable major life stressors that were looming in around him, apart from his clinical

diagnosis?

A. Sorry, that came from his clinical diagnosis?

Q. No, apart from a clinical diagnosis of PTSD, depression, mixed personality traits, what about his life stressors?

A. I think, yeah, he did have what I would consider to be significant life stressors. Selling the house was a stressful situation. Planning his move is another stressor. And moving in ... trying to take on the role of father and spouse which he hadn't taken on for many years. All of those things would be considered significant stressors, yes.

Q. What about his sense of employment or what he was going to do to earn an income?

A. You know, he didn't talk about ... I know he talked a little bit about wanting to work because he did want to support his family, but he had ... mainly he talked to me about how difficult it had been to work with civilians. He found that he couldn't tolerate that civilians might take an hour and five minutes for lunch instead of an hour. It wasn't as precise as the military would be. So he had mentioned it as something he'd like to do eventually, but he did acknowledge at the time with me that there were things he needed to work on before he could

consider trying to get a job.

Q. And, again, was he sort of struggling with this concept of, there's employment in the military setting, like you said, they tell you 45 minutes for lunch and people take an hour, and a struggle with, How I am I going to be employed in Guysborough or a regular ...

(10:00)

A. Yeah, that he ...

Q. ... or a community, I guess?

A. Yeah. He mostly ... I think his primary concern at the time was being able to tolerate just being employed in a civilian setting. He didn't mention the specifics of it, just trying to find work in that community.

Q. You indicated something, and I'd have to search through my notes. I was going to get to it later, but at one point in one session, Lionel Desmond indicated to you that he wouldn't take a lunch unless he was sort of discharged. Somebody told him, You're now discharged to go to a lunch?

A. Yes.

Q. Is that the case? Could you tell us a little bit about that?

A. Yeah. That was one of the things he had about his

attempt to return to work, that he was so ... I mean he was accustomed to being in a workplace where everything was dictated. What time you arrive, what time you leave, what time you take your lunch. It was ... there was no personal choice or flexibility, which is not ... you know, that's fairly typical in the military setting.

So when he went ... I think he was working in a garage as a mechanic. He said, Yeah, he didn't ... he was very strict with himself. He didn't ... unless someone told him, Okay, now it's your lunchtime, he wouldn't go. He thought that that was what a good worker did. And so that ... it's not uncommon either. I speak to a lot of people who simply ... they find it too hard to integrate to a civilian workplace because things are more flexible, things aren't as strongly structured and it's not as black and white in terms of what the expectations are.

So it was something we discussed and it's something that comes up very often with veterans.

Q. So to you, did it highlight that ... was that an example of highlighting that difficulty he was having suddenly transitioning from military member to civilian?

A. Yeah. It definitely highlighted the difficulty transitioning. It highlighted some of his more rigid thinking

patterns. And also he had mentioned as well that just seeing oil stains on the floor bothered him. So that may have been some of the OCD coming in, which is not my area of expertise, so we didn't delve into that. But there were a few barriers to transitioning.

Q. And what was he having sort of ... he's a mechanic and naturally you would think, okay, a mechanic is going to be around dirt, grease, and oil, but he was having a struggle with that. What do you mean? What was this ... give us a sense of what his struggle was.

A. Just seeing the stain caused him to ... he didn't like it. It made him uncomfortable. And I think, without knowing a great deal about OCD - it's not my area - he attributed it to that, to the ... the OCD made it difficult for him to tolerate that things were messy.

Q. Okay. And would this sort of ... so again, I guess, is it fair to say we're seeing an interplay between a psychological diagnosis and coupled with a sort of life stressor in a transition? We're seeing an interplay between the two?

A. Mm-hmm.

Q. I see you nodding. I guess ...

A. Oh, yes, yes. Sorry. Didn't mean to go there.

Q. So were there a number of things that ... there was an ongoing interplay between a psychological diagnosis, a life stressor, and a transition. So three prongs to what he was trying to navigate?

A. I think yes. I mean he was going through the transition of, from being a soldier to being a veteran, being military to being civilian, so that's ongoing. And for many veterans, that takes many, many years before ... and sometimes forever. They never feel like they've fully made that transition. So that was underlying everything. And then, of course, there were the psychological factors that they play off of each other certainly.

Q. Okay.

A. The transition can be a stressor and the psychological issues can be ... lower their resilience to handling the stressors.

Q. I'm going to turn to ... it's marked as Exhibit 254 and it's going to be page 268. We're going to eventually turn back to this document, but I just want to sort of set down some firm timelines on the record. So this document ... do you have it in front of you?

A. I do.

Q. So it's the interdisciplinary discharge summary and it appears as though, if we ... on page 274, it appears as though it was prepared on October 4th of 2016. Was it you that prepared this discharge summary?

A. Yes, yeah. I sent out an email to my colleagues saying that we need ... I need their observations and recommendations in order to put together this document.

Q. So in the Ste. Anne's clinic structure, is it typically the social worker that would oversee pulling all the different resources together, compiling them in a report?

A. Yeah. At that time, yes. Since, it's changed. It's now become the admissions nurse that does this but at the time it was the social worker who pulled it together.

Q. Do you know if there was a particular reason why now it's an admission nurse as opposed to a social worker?

A. It was something that we had discussed for a long time just ... it seems that the admissions nurse has a great deal of contact with the team that has referred, so it began to make more sense for the person who had the most contact with the referring team to be the one to gather all that information and to set up a teleconference. So it just sort of happened in that way.

Q. So as I understand it, the referring agency might have the most contact with the admissions nurse. Is that correct?

A. Yes.

Q. And so logically, I guess, if the admissions nurse is gathering the information, they relay it back.

A. Yes.

Q. So this particular report, it outlines that ... it says, "Monday, May 30th". That was sort of Lionel Desmond's first day at Ste. Anne's but in the stabilization program?

A. Yes, that would've been his admission date, I believe.

Q. And again, we're still on page 268. It says, "Transferred to residential program July 4, 2016."

A. Yes.

Q. So that would've been when he was actually then, first day, enrolled in the residential phase?

A. Yes.

Q. And date of discharge, it says, "August 15", I'm assuming 2016?

A. Yes.

Q. And I understand you had a case conference with the external treatment team at some point in early August of 2016?

A. Yes. I'm not sure if the date is in here but it

would've been in his last week of his stay with us.

Q. If you could tell us generally, what is the purpose of that conference that takes place between the Ste. Anne's team and the external team? I guess before I get into the purpose of the conference, who participates in that phone call?

A. We invite the case manager and all members of the external team. So the psychologist, whomever is involved in the treating team for the client. On our side, we have anyone who was ... pretty much everyone on our team is involved in that, so everyone who saw the client, whether in group or in individual, is there to share our information.

Q. So when you say "case manager", are you referring to Veterans Affairs case manager?

A. Yes.

Q. And when you say "referring team", in Lionel Desmond's case, that would've been the OSI New Brunswick?

A. Yes.

Q. Do you recall who ... do you recall the names of any of the individuals that were there?

A. I do not, no. I was just looking. Normally, sometimes I would have it in this report but unfortunately, no, I don't recall their names.

Q. And from the Ste. Anne's end of things, do you recall who would've been present for that, I guess, that phone call?

A. Yeah. That would be myself, Julie Beauchesne would've been there, Isabelle Gagnon - Dr. Gagnon. Trying to think. Dr. Ouellette may or may not have been there. He wasn't always able to make it to our teleconferences. Who else would've been there? We would've had the occupational therapist which, at the time, was actually ... Julie Beauchesne, I think, was doing both at the time. And the educator was there, Marie-Eve Royer, who probably didn't say anything because she hadn't really worked with the client a great deal individually.

Q. And do you remember ... and I know it's a while back. So what was the purpose of organizing this internal team, Ste. Anne's, with the external, the referring agency, Veterans Affairs? What was the purpose of this as it relates to Lionel Desmond? Why was this happening?

(10:10)

A. So this happens with all of our clients and it's something that is a very important part of preparing for that transition back home is to make sure that all of the recommendations that we have come up with, all of our observations, that they can be shared with the external team,

where they are given the opportunity to ask questions, if they have any clarifications to make, and that if we have any concerns or strong recommendations, that would be the place where we would say, Okay, you know, this is the area that we think you should prioritize. These were the challenges that he faced and these are the improvements that he made while ... the therapeutic gains that he made while he was with us.

So we do that ...

Q. Go ahead, sorry.

A. ... to share all that information, and we do it specifically on the phone in the last week because there is often a delay from the time the report is ... in getting the report together and the hard copy of the report being received by the team. There's translation, there's a variety of different factors, but often, there's a bit of a delay, so we find it very important that, verbally, they get all of the information from us before the person leaves our program.

Q. So, and I'm mindful that the report, you know, it contains a number of details and the report has recommendations from the psychologist, recommendations from the occupational therapist, recommendations from social work, recommendations in terms of medically. Would those have been outlined to the

referring agency? In Lionel Desmond's case, would they have been outlined to OSI New Brunswick and Veterans Affairs, Marie-Paule Doucette, that these are the things that are going to be needed for Lionel Desmond when he goes back to the community?

A. Yes. Yes, all of those things would've been named in that teleconference.

Q. So as a general rule, from what I take it you're saying is, even though there's going to be a written report going to be provided down the road, those aspects would've been communicated at that phone conference?

A. Yes. Yes. We try to make sure that everything, all of our recommendations are communicated verbally in that teleconference.

Q. In Lionel Desmond's case, would they have been articulated in a way of ... for example, there was a recommendation that he participate in the Wounded Warriors program. Would something like that have been conveyed on that phone conference?

A. Yes, it would've been. All of the things that are ... often, for myself anyway ... I can't speak for my colleagues, but I will ... I've already written my report before I do the teleconference, so anything that I wrote in my report would've

been shared with them verbally, including the recommendations.

Q. And is there any discussion ... was there any discussion about why ... you know, it's one thing to say, you know, Lionel Desmond should be involved in the Wounded Warriors program, but it's another to articulate why it was important. Would there have been any sort of discussion about that at this phone conference?

A. Yes, there would've been. When I share the recommendations, I will also give a brief explanation as to why I think he might benefit from it. So specific to the Wounded Warriors program, he was specifically interested in the equine, the horse therapy aspect of that program, and I highlighted it because socially, you know (inaudible - audio) skills and (inaudible - audio) he had difficulty with his interpersonal skills. Oftentimes, having a relationship with an animal, horses, in particular, can be quite therapeutic. It's an easier place to develop a connection. They feel safer. The trust is established, so it transfers, but it's a good place to start when someone is having more interpersonal difficulties.

Q. We're going to get into all of the details of your recommendations at some point, but since we're here, you had recommended ... one of your recommendations is that he have a

clinical care manager.

A. Mmm.

Q. Would that have been ... and you documented that in your recommendations. Would that have been conveyed at the phone conference?

A. Yes. And actually ... yes, that's a detail I actually remember vaguely, but I remember it being discussed and that someone from the New Brunswick clinic said they were working on getting someone right away in Nova Scotia to try to help with the transition. And I may be wrong. That's what I'm remembering, that they were taking that seriously and trying to get someone as quickly as possible to help set up the services in Nova Scotia.

Q. And from your standpoint, was a clinical care manager something that was very important for Lionel Desmond?

A. I wouldn't necessarily have prioritized it. I think it was something that would've been helpful given that he was moving to a new community, to help, not do things for him, but work with him to choose where he wants to prioritize his time and help him to set things up. So yeah, I think it was important, but not necessarily moreso than some of the other recommendations.

Q. Sure. So I'm just going to ask you a little bit. I'm mindful of the fact that you have to gather information. And sometimes when you're in charge of gathering information from other people, they're out of your control and that can be frustrating. But the report doesn't seem to get prepared until October. What was accounting for the delay there? So he leaves August. So it's about a two-month delay in this turnover of care. What was accounting for the delay in the report?

A. Without throwing anyone under the bus, it's waiting for people to get the reports prepared and send them to me. And then there's another ... so waiting for that process can sometimes take a little bit of time and then waiting for things to be translated to English because most of my colleagues were writing in French, so the translation adds a little bit of time.

Q. And so the report gets prepared, I believe you had said, and it's confirmed, it was October 4th. So who did you send this report to, do you remember?

A. I would've sent it to the treating team, to the case manager - the VAC case manager - and to the treating team in New Brunswick.

Q. And you said ...

A. And they also ...

Q. And you said "VAC"? Just so I make ...

A. Yes, the VAC case manager.

Q. Okay.

A. Yeah. So there's a few people on the list. The people that are normally on the list would be everyone who is on the treating team in New Brunswick. The OSI clinic who referred him and the VAC case manager would've gotten a copy. And just to add to that, when I send that document, Archives also sends along the medical notes that the psychiatrist has written. So if there's been any extra ... any diagnoses or change- ... all the things with the medication are sent, as well as any diagnoses that the psychiatrist has posed.

Q. So normally you said the psychiatrist notes and the actual diagnosis is sent as well?

A. Yeah. Well, that is included in. It's not part of the document that I prepare, but when the document is sent, Archives will send that last ... the medical notes as well.

Q. So just so I understand. So we know, in this case, Dr. Ouellette had set out a specific diagnosis. It was PTSD. I'm going to paraphrase because it's not word for word what he had said, but PTSD, chronic intensity, major depressive disorder, chronic intensity, comorbid alcohol in remission, and

mixed personality traits. That was his diagnosis.

So you're saying that Archives would normally send a document with his diagnosis to Veterans Affairs and the somewhat referring agency, the OSI clinic in New Brunswick.

A. Yes. That's the process that we do, yeah.

Q. So when you have your report, do you turn your report over to Archives and then Archives sends it? Is that how it works?

A. Yes.

Q. Do you gather the report from the psychiatrist and bring it with your discharge summary to Archives or ...

A. No, I don't ...

Q. Go ahead.

A. Yeah. I don't gather the report. I write ... I'll put together my report and I'll write a letter, sort of a cover letter, saying to Archives, We need this report along with this one and this one. And then they put all those together. They pull out the reports from Dr. Richer, the general practitioner, and Dr. Ouellette, whichever the treating psychiatrist is, they'll pull out their reports and send it along with the discharge summary.

THE COURT: I'm going to stop you. So Ms. Hamilton,

just so that I understand it, from the time that Cpl. Desmond registered at the clinic till the time that he left, all of the various medical records, everything that you would've compiled while he was there, would that entire package of documents have been sent to Veterans Affairs Canada along with the discharge summary?

A. No, it wouldn't have been every single note that we ... that was in his file. It would've been just the discharge summary and the final ... the closing note of the psychiatrist and the general practitioner.

THE COURT: All right, thank you.

A. You're welcome.

MR. RUSSELL: And I realize you may not be able to comment on the policy reasons, but is there a particular reason that you understand why the entire file sort of isn't provided to Veterans Affairs Canada and then, ultimately, the referring agency, through Veterans Affairs?

(10:20)

A. I can't think of a policy-type of reason, but just logistically, there's hundreds and hundreds of notes in there and I would think ... it would ... it's going to be a better form of communication to send this summary with the most

important highlights, the things that we found to be important for his continued recovery. I think that'll be more effective. If we send a huge binder with hundreds of notes, the time it takes to get to the heart of what we're trying to say will ... might delay things. I don't know how helpful that would be.

However, we do also tell ... when we do the teleconference, we're very clear that people can call us back at any time if they have questions, if they need more information, if they want more details on a specific situation. So the door is always open for that communication, but in terms of the paperwork sense, I think having a summary with our recommendations is the most effective route.

Q. So is there any process, sort of an internal process ... and I can understand the merits in saying, Here is five pages, so you're not overwhelmed, that's going to very much hit the highlights so we can get this off the ground. But is there another process where what is to follow will be, you know, this report, everyone's report?

A. At this time, that process doesn't exist. We don't send the whole report. Unless someone were to call us and say, We really specifically need your notes surrounding this incident, or, We want to see all of the OT's notes, then, with

permission from Archives, we would certainly comply with those requests. But at this point, no, we don't ... once we've sent the discharge summary plus the medical notes, we don't send anything else unless they call to ask.

Q. Okay. We're going to turn back to sort of Lionel Desmond. Can you give us a sense of when you first would've met Lionel Desmond at the clinic, approximately when that was?

A. It would've been in his first week of arrival. If he arrived on a Monday, then I usually try to give them a couple of days to settle in and I try to schedule an appointment on the Thursday or Friday of the first week that they arrive in the program.

Q. And so you consistently sort of were Lionel Desmond's social worker in the duration of his stay at Ste. Anne's?

A. Yes.

Q. And how frequently, and we'll go through your specific sessions, but how frequently, whether it was individually or in a group setting, would you have met with Lionel Desmond over the course of May 30th to August 15th?

A. If we include the group sessions as well as individual, it would be one to two times per week that I would've seen him.

Q. Why ... is there an importance behind the consistency and frequency of meeting with him?

A. There's an importance behind the consistency in terms of maintaining the length with an individual, but we also ... it will vary from time to time. Sometimes, you know, if I look at the calendar and I see someone's got psychology, OT, psychoeducator, all in one week, I might say, Okay, well this week, I won't see him because he's already got enough. And that, I would usually share with the client to see how they feel about it. If they want to see me every week or if they would rather take a break. So it usually varies even from week to week, in collaboration with the client, how frequently they want to continue their appointments. But it's never more than ... it's at least once a week if not, every so often, every two weeks at a time.

Q. Generally, with Lionel Desmond, did you see benefits to him having a structured routine?

A. I did, yeah. I think he ... but I didn't see it more necessarily than other people. I think everybody benefits from that structure, and definitely, when he arrived, he enjoyed being able to go out on his bike, he enjoyed having the people around him, from what his reports were. So he did benefit from

it, but we didn't notice that it was necessarily moreso for him than for most of the people who come through the program.

Q. I guess I'll ask you a question in terms of, we talked a little bit about someone that's involved in a military structure where they're used to, You'll have your lunch when I discharge you for lunch, to, in a clinic setting which is structured again, and that transition to the community, do you see any sort of potential for you're losing structure when you go to the community in terms of a healthcare setting?

A. It's always something that we are aware of in the transition for everybody that you're going from structure, from endless supports, 24/7 support, to a more isolated situation, potentially, with support continued but not as intensive. So it's something that we're all aware of and we talk to them about that transition. And it can ... it certainly does make the change difficult, but as long as, for most people, so long as there is some continued contact with a treating team along with the other factors that I discussed - leisure and so on - then they get through that transition. It's a little bit rocky, but then they find their rhythm once they're home.

Q. Is it fair to say, with the complexity of Lionel Desmond, that he benefitted from having more than just one

social worker or just one psychologist, that he benefitted from psychiatry, psychology, social work, occupational therapy, recreational therapy? Did he benefit from a collaboration of resources?

A. Again, it's sort of the same. I think that, yes, he did, but not moreso than others and not necessarily due to the complexity of his case. I think he benefitted from it because when you're in a space where that's all you have to work on is your recovery and your treatment, having that intensive ... the opportunity to work with a variety of different professionals allows us as a team, and allows them as an individual, to figure out, Okay, where are the major problems and what areas do we need to focus on?

So yes, he benefitted from that, but I wouldn't necessarily recommend to anyone that they need, and in the community, try to recreate that same level of service. The reason being that while they're in our program, their full-time job is working on getting well. So the illness becomes central to what they're doing. When they're at home, we don't want the illness to take up five days a week. It shouldn't ... it wouldn't ... his full-time job should not be therapy. His or anyone else's. So we believe that someone ... we need to find that balance wherein

all of the different areas, the spheres are there, about things that attribute their well-being ... contribute to their well-being, rather - including therapy - that those things are present, but the therapy doesn't take a bigger piece of the pie than any of the areas that contribute to their well-being.

Q. So I appreciate that. I'm also looking at documentation that says "Recommendations", and when Lionel Desmond is going to the community, we have a recommendation that he see a psychiatrist because medication is important. We see a recommendation that he see a psychologist because therapy is important. We have a recommendation that he have an occupational therapist to help him structure his environment. We have a recommendation that he have a clinical care manager to help him navigate his day-to-day affairs and we have a recommendation that he be put into various resources.

A. So yes. So if you do all of those things all at the same time, it becomes what I just described, sort of a full-time job. However, when we do make those recommendations, we don't necessarily mean that they all be done right away, all at the same time. These are all things that we think that he could benefit from when he ... in his continuation of his recovery, but it's something that he and his therapist, whoever he's

working with, they would work collaboratively to decide, Okay, well, what do we prioritize? What do we ... what is most important here? And maybe for a little while they will be sort of ... have a lot of different therapists as they get themselves settled, but the end goal would be to have enough support but not too much but ...

Q. And you compiled everything from all the different resources within Ste. Anne's. So when Lionel Desmond left on August 15th, what sort of healthcare or community supports did he need and need pretty much within the first month of leaving?

A. We felt he definitely needed to continue ... one of the things that we highlighted was his exploration factor of trying to figure out, tease apart what, you know, if there's personality traits that were causing more of the problems or if it was maybe a brain injury, again, that's not my area but it was one of the things that, as a team, we had considered important to explore. What are these underlying factors that we're not ... we haven't done a profound (inaudible) to, that, you know, we would see identified before they may be blocking him from progressing. So that was we felt was most important.

And then we ... other than that being of primary importance, it was continued support in the form of

psychologists. Definitely, his medication needed to be followed for sure. But ... (inaudible - audio) ...

Q. What about ...

A. ... other than ...

Q. Sorry?

A. Sorry. My train of thought was a little ... went off track there for a second.

Q. I can sort of navigate. So was it ... obviously, there were issues with medication, so it was probably helpful that he stay connected with a psychiatrist in the early days of leaving?

(10:30)

A. Mmm.

Q. Yes?

A. Yes, someone to make ... yes, sorry, yes. It would've been ... he had ... something that his wife had told us was that he wasn't always compliant with the medication, so we did think it was important for him to keep seeing someone to follow that.

Q. So in many ways ... and I can certainly appreciate that the goal is that the treatment and wellness not become a full-time job when you get back to your community but it appears, is it fair to say, that in Lionel Desmond's case, when

he got back to his community, there was a significant amount of work that was needed?

A. Yes. He was at the beginning, we felt, of a long road. There was a lot of work to be done for him.

Q. And at the beginning of a long road, if it's not a full-time job in the community getting well and accessing resources, in Lionel Desmond's case, based on the recommendations, would it certainly have been a part-time job?

A. Yeah, that's fair to say, yes.

Q. Would it be fair to say that he needed maybe more than one person, one just general therapist, and check out the ER once in a while when he needed it?

A. Well, I don't ... I can't speak to you how ... what his state was after he left us. When he left us, I think we envisioned him having, again, not all of those recommendations necessarily all at once, but definitely psychological support and the psychiatry. Having at least one or two ... I even hesitate to be this specific but, yes, generally speaking, having at least one or two contacts, therapeutic support, and someone following his progress would've been important.

Q. In the early days of his referral to Ste. Anne's, how would you describe Lionel Desmond's motivation to sort of get

better and achieve the goals that he wanted to achieve?

A. He was motivated. He was very clear in what he wanted to work on. He was respectful. He came to all the groups. He came across as someone who really wanted to work hard.

Q. Did his motivations or attitude sort of ever shift as he went along with the program?

A. Towards the end, I think he started to become discouraged and things, you know, Shanna had set certain conditions on his coming back and that made him feel insecure. So he was a little bit more discouraged. He was still using the strategies that worked for him. He was still doing his exercise, doing his outdoor time cycling, so he remained motivated to continue practicing the strategies that he felt were helpful to him, but I did notice in interactions, I would see more, just body language of discouragement, with his head in his hands and so on.

Q. From a social worker perspective, what therapeutic goals did you identify with Lionel Desmond? What were the areas, from your perspective, that you wanted to work on with him during his stay?

A. So he identified communication and becoming a better father and spouse, and I sort of expanded that with him to

include just a social network, in general, to see if we could identify areas where he could expand his social network.

Q. So if we could turn now to sort of specific sessions and we're going to highlight some various points of those sessions. First is page 248. This is a group therapy anger management, June 5th. What was the purpose of this group therapy session?

A. The group was an anger management session. The group that we discussed earlier, PEACE. It's ... the session focussed on understanding triggers for anger; specifically, what types of feelings might be triggers for anger. So we explained that feelings such as guilt, shame, or sadness can often trigger anger in the sense that guilt and shame are turned inwards and they're quite painful, whereas anger is more easily externalized. It gives you more a sense of control. So often when we're having an angry outburst, if we stop and we rewind and think about where it came from, it often stemmed from a sense of shame or guilt or sadness that just got transformed because we're uncomfortable with the former emotions and anger is an easier one to externalize.

Q. And I understand what became highlighted during this session was some discussion that he had anger or a disagreement

as well with another resident?

A. Yes, yeah, he did discuss something.

Q. Do you remember what the confrontation was or the difficulty was between Lionel Desmond and another resident? This is a week into the program and he's having some sort of conflict with another resident. What was it?

A. I unfortunately don't remember the details of the conflict. I think someone said something that he was offended by ... but yeah. So even ... I'm not surprised that it's not in here because normally, when there is a conflict, I try to ... the details of the conflict are less important than the process the person is going through in trying to manage their reactions. So with him, we would've tried to help him to see things more from the perspective of, Okay, so this incident caused you to feel this way. How can you manage this emotion and express it in a more helpful way?

Q. So in this group context, how was Lionel Desmond as he's navigating this conflict and relaying the conflict?

A. He was having a really hard time moving away from the details of the conflict, and I think it says that I had to eventually pretty firmly ask him to stop because he was talking a great deal about this other resident who wasn't actually in

the room at the time and he didn't seem able to ... he was too activated or he didn't seem able to be able to discuss ultimate ways of reacting to the situation. So it eventually became necessary to ask him to stop discussing it.

Q. And what was his reaction when you actually had to sort of intervene and say, you know, You have to take a step back from this. You're in a group setting. What was his reaction?

A. Well, he had a hard time stopping. He continued sort of muttering under his breath, but I think Mr. Desmond was someone who, he was very respectful of rules and of a person perceived as in an authority position, so he did stop. It just was almost too much for him to stop completely, so he sort of muttered under his breath for a little while and then that eventually stopped. But he didn't demonstrate any hostility towards me and he was able to stop himself.

Q. So clinically, what are you making of this at the very early stage? A week in, it's the first group session. What is this illustrating that maybe Lionel Desmond had to work on and how do you go about it?

A. Well, it definitely demonstrated some rigidity in his thinking, and it also demonstrated the rumination factor, sort

of being unable to let go of something, that the thought sort of stayed in the head and being unable to step away from the ... they often refer to it as the hamster wheel. That ... it showed those two things, the rigidity and difficulty stopping the rumination.

Q. So the rigidity and the difficulty in stopping the rumination, is that something that continued through the duration of his stay at Ste. Anne's?

A. At times, but he actually showed a couple of incidents where he was able to step away from it and calm down, even in a situation where he was very, very activated. So he did make some progress there. It was something also that his wife had identified to me is that he would become obsessed with a certain thing. If someone had offended him, it would be very, very difficult for him to stop talking about that thing. But we didn't notice ... it happened a couple of times, but not extreme, not lasting for days and days, just lasting for, you know, a couple of ... a day or so and then he would be able to move on.

Q. So if we turn to page 238, this is June 9th. This appears to be ... it's titled, "First meeting", so this is the first time you met individually with Lionel Desmond?

A. Yes.

Q. So there was a discussion about medication and Seroquel. Did he indicate to you how he felt Seroquel might've been helping him or not helping him? What were his views of it?

A. Yeah. He was very positive about the Seroquel. He said that it was helping him. He had more energy. He felt rebooted. He thought it was ... it had been a good addition.

Q. There was some discussion about a goal. He identified a goal of being a better father and husband. Did you sort of flush that out with him?

(10:40)

A. I tried. He was very clear of what he wanted, but he had a more difficult time breaking that down. He knew he wanted to be a better dad, he knew he wanted to be involved and have a good relationship with his wife, but he wasn't really sure what those things meant. And it kind of makes sense in a way. I believe that he spent more time apart from them than he did with them, so understandably not really knowing what those things mean it kind of makes sense in the context of the way that their relationship had played out.

Q. So I guess what do you mean by saying he identified wanting to be a better father and a better husband, then you

said he had difficulty defining what they meant. What are you making of that, that he's able to say what he wants, but he doesn't seem to appear to understand what he wants.

A. Well, at the time - and it's my first meeting with him - I wasn't quite sure what those reasons were. In a first meeting, it could be that the person is still defensive. They still don't feel quite safe to open up. It could mean that they really ... in his case, really just don't know. He has this goal, I want to be a better dad, but he doesn't really know what that means. He ... from my recollection, he had ... his father was absent for most of his childhood, so perhaps he's never seen a model of what a good dad is and he hadn't really been involved very much with his wife and daughter since she was born, so he didn't ... he just didn't know, I think.

Q. Did he continue to struggle with being able to say something, but lacked sort of an understanding of what it would take to get there?

A. Oftentimes, yeah, he had difficulty getting into the details and breaking things down in a logical way. He didn't seem ... he would have ideas of what he wanted, but it was very difficult for him to break it down.

Q. And at this first session, you had noted in the last

paragraph, you said: "He frequently mentions communication as problematic for him in his relationship with his wife but cannot identify specific areas in which he could improve."

A. Mm-hmm.

Q. So did he seem to have some insight into, Communication with my wife is a problem, but I don't know how to fix it?

A. He didn't have much insight at that time. He really ... and at the time the more I pushed, I thought, oops. He just didn't know the answers. And I can't really explain. At the time, I couldn't explain, and I still think there was some underlying things that stopped him from being able to organize his thoughts in a way. But yeah, we tried various different ways to go about identifying, What does that mean to you? Where are the areas that you struggle more?

He did ... I didn't mention it here, but along the way, he did mention that he has difficulty controlling his temper, so he would acknowledge that that was something that interfered with his communication. But, yes, getting into the details was difficult.

Q. You said: "He is sensitive to the importance of maintaining control ..." It's in the same paragraph. "He is

sensitive to the importance of maintaining control of his anger, particularly in the presence of his daughter, and identifies learning anger management skills as needed." So is he expressing some insight in recognizing, I shouldn't be angry in front of my daughter?

A. Yes. In this case, yes, he is aware that his outbursts had an impact on his daughter.

Q. Did he describe how frequent those outbursts might've happened in front of his daughter?

A. No, he didn't go into detail on that. He just said that he was easily angered and had difficulty controlling it.

Q. Did he express ... articulate what impact they were having on his daughter?

A. I may be getting it mixed up with what his wife told me, but I think he was aware that she was ... that she found it upsetting, that she was nervous because she wasn't sure how he would react.

Q. His dau- ...

A. But, like I said, that's not written ... I could be mixing that up with what Shanna told me.

Q. Okay. So at this very early stage, the goal identified, you say, and it seems to be the only goal listed

right here is, Developing healthy communication strategies with aim of improving relationship with his wife.

A. Yes.

Q. So can I take from that that at the very first session, the primary focus seems to be improving his relationship with his wife and daughter as the identifiable issue?

A. Yes.

Q. And it's the identifiable issue from him, but also from you?

A. Yes.

Q. So was this going to be sort of a prominent focus during your time with Lionel Desmond is to work on this relationship with his wife and daughter?

A. Yes, that was the plan. In the end, when I go through all the notes, there were a lot of distractors at the time. We talked somewhat about his wife, that there were frequent ... whether it was a conflict with another resident or a conflict because he was upset about the visit that he thought was supposed to be paid for. There were a lot of things that were dedicated to helping him manage his reactions to different stressors.

Q. Okay. If we could turn to page 240, this is the same day, June 9th. It's a group therapy social networking and I believe you indicated that Lionel Desmond had been talking about a telephone conversation that he had with his wife?

A. Yes, he brought it up in the context of the group about communication. He didn't give all of the details. Basically, they were having a conversation and she'd encouraged him to focus on himself and he seemed quite ... he seemed to have interpreted that as somehow discouraging him from ... something negative. He interpreted that as something negative rather than of good intentions of her wanting him to focus on his health and get better.

So we encouraged him to try to speak to her, to ask her what she meant by it, to let her know that he felt insecure when she said that, and to verify with her what she meant so that he could stop, you know, wondering and creating scenarios.

Q. So did he seem to have a pattern of almost overanalyzing or taking a negative sort of view of what his wife was trying to say to him, or taking something that might be sort of innocent on its face and thinking that it has some sort of malice behind it?

A. We didn't see that specifically only with his wife.

It happened a number of times that he attributed negative ... well, I say a number of times. It happened more than once that he attributed negative intentions to what somebody else had done. So, yeah, I think he did it with his wife but he also did it with others.

Q. Okay. If we could turn to pages ... it's between 241 and 243. This was a report prepared by you June 15th and it's called a "Social Functioning Evaluation". So we're two weeks, about two weeks into the program. What is a social functioning evaluation and what's the purpose of you doing this?

A. The social functioning evaluation allows me to get an understanding of how the person is interacting with their environment, and their environment being all the things that surround them at home. So what friends they have, what their family life is like, what their leisure life is like, what their social life is like, if they have religious beliefs, if they attend a church, if they have hobbies, if they have extended family. It gives a big, holistic picture of how they're functioning in their environment. And in that exploration, that's where, collaboratively, we'll find, Okay, so, you know, you're not ... you don't leave your house so you never see your friends. So this might be an area we might want to work on. Or

you're fighting with your wife, so this is an area.

So it's a holistic exploration with the aim of trying to figure out where are the areas that need the most work? What's going well, what's not going well, and how can we address those challenges?

Q. So I'm going to look and break it down with a series of questions. Under "Characteristics of the Person", you single out social network. What was it about ... what did you note about Lionel Desmond's social network that appeared to be, I guess, problematic for him, or what sort of structure was problematic?

(10:50)

A. There was a couple of things in there that caused me to think that he was quite isolated. One of them was just the fact that he was living alone in New Brunswick, separate from his spouse and his daughter. Another was his comments about when he was in the military, keeping to himself and not really having any friends. He also didn't mention, when I explored, you know, What do you do socially, who do you see? He couldn't name anybody that he saw socially. So those were ... I really ... I got the sense that he was very isolated and didn't have really a lot going on. And even when he talked about his

relationships with his family growing up, he didn't speak of close relationships. In fact, he talked of trying to get out of the house as often as possible because he found it too noisy. So it seemed that for a long time, he has ... he didn't have a lot of social supports around him.

Q. Did you get a sense that he, for a number of years in adulthood, had a close relationship with his siblings or did he appear more isolated from them?

A. He didn't mention his siblings at all, actually, in the course of our discussions. He simply ... he described his childhood home as being too busy, too many people, and that he would often leave to get away from the noise.

Q. And you note in the first paragraph under "Social Network", you say, "It is unclear how much, if any, contact he has had with his wife and child for the past seven years."

A. Yes.

Q. So what sort of ...

A. Yeah. He ...

Q. Go ahead.

A. He wasn't able to ... I tried to explore, Do you see each other at holidays? Do you see each other, you know, when your child is on summer break from school? And he really had a

difficult time say- ... identifying ... Well he would ... sometimes he said something along the lines of, Well, sometimes they come to visit me, but I'm not ... I wasn't there. I was away. Or, At Christmas they were supposed to come, but I called them and told them not to because the weather was too bad.

So, you know, with all the gentle exploring that I did, I couldn't get a sense of how frequently he saw his family.

Q. In terms of a military background, he brings up a little bit about what's listed here as "OCD Tendencies". This is on page 242. What was that discussion?

A. He mentions that the OCD tendencies, he feels, helped to make him really good at what he did. Really good at basic training and the skills that were required to get through military courses, that he was able to maintain his barracks perfectly cleanly, and he was able to get his uniform ironed just right and his boots polished just right. So it made him very, very good at it. But we didn't ... you know, because OCD, that would've been something I would've referred to Dr. Gagnon or Dr. Ouellette because it's not my area, so he talked about it having been a strength for him. We didn't get into anything beyond that.

Q. On the same page, how did he describe his financial

situation?

A. He ... in that first couple of weeks, in this meeting, he had told me that he was quite stressed financially, that he gave the impression he was at risk of losing his home and that he had to pay for his wife's nursing degree, and that he often didn't have enough money at the end of the month.

However, I know you're going to ask questions about this later, but at a later date, there were some things he said that really put this whole paragraph in a different perspective. I don't know how much of this is accurate.

Q. So you sort of ... initially, he relays this information about the financial situation, but you later get some information that's contradictory?

A. Yeah. At a later date, he told me that his wife, one of the conditions she had for him returning was that he let her handle the finances because he became easily overwhelmed and couldn't keep on top of bills. And he actually said to me at the time, Well, it makes sense for her to do it. She's really good at it. So, you know, that sort of contradicted with the idea that she was taking all of his money and leaving him with not enough to pay bills.

Q. So on the one hand, he's telling you, She's great with

the finances and perhaps she should be handling them, and then on the other, She's misappropriating funds and she's mismanaging funds.

A. Yes.

Q. So what do you make of that contradiction? So on two different occasions, he basically tells you two different things.

A. Mmm. I think the first spoke to his insecurities, his suspicions of her, because he did go through periods of time where he was suspicious that she was just using him or taking advantage of him. So the first meeting was him expressing those insecurities and the beliefs that came from those insecurities, and the second was, after having spoken to Shanna and he was perhaps a little more trusting or perhaps in a different head space where he was able to acknowledge, Well, actually, she did pretty well.

Q. At page 243 under "Impressions", you describe that he has difficulty staying focussed, answering questions in a direct manner, a tendency to speak rapidly and at length in a tangential manner. Was this posing sort of a difficulty with you trying to get a narrative from him or keep him on task of what you were trying to do in a therapy session?

A. It did, yes, it did make it difficult to nail down what exactly he ... how we were going to create an intervention plan, how we were going to go about working towards achieving the objective that he'd identified. It was ... yes, it created somewhat of a barrier to making a solid plan with him.

Q. And ultimately again, similar to what we saw earlier where the goal was identified of relationship with his wife, what was the intervention plan identified as a result of this social assessment?

A. Overall, with the intervention we developed was to explore communication and communication styles. He named communication and I've actually thought well, maybe if we break it down into different types of communication because the military culture tends to adopt a more aggressive form of communication which often causes a problem when military members return to their families, where most people in civilian roles prefer a less aggressive form of communication. So that was part of the intervention plan was to figure out ... to do some education on what communication is, what the different styles are, and what he thinks his common style of communication is. The idea being, the long-term idea being, that if he could identify that his communication style was more aggressive, then

we could work on practicing other forms of more assertive, less aggressive forms of communication. And then the second thing is to help him develop the concept of what it means to be a good father and to be a good spouse. What he would need to ... what skills he would need to adopt and what things he would need to do in order to reach that goal.

Q. So after the social ...

A. That ...

Q. ... functioning exam, if you were to give it a sort of letter grade in terms of his social functioning in that snapshot when you meet with him about his social functioning at home in his community, is it an A-plus or is it a D?

A. I've never, ever thought about it in terms of A to D. I would ... I guess a C. He wasn't functioning optimally, but he did have an ability ... like, on the unit, (inaudible - audio) he had a ... he was able to adopt a really friendly demeanour, a polite and respectful way of approaching people, so in some ways, on the surface at least, he had an ability to interact with people in a healthy way. Delving deeper, you could see there was more difficulty. So B, C, I guess?

Q. So if he's a C, in clearly need of work.

A. Yes.

Q. So to page 249. This is another group therapy session, June 16th. What is an ecomap?

A. An ecomap is a representation of a person's social network, so I give them a form, a piece of paper. In the middle of that piece of paper is a circle where they write their name, and then surrounding that circle are a variety of other circles, and they fill in each of the circles, the various members of their social network. And they can put parents, siblings, friends, church, spouse, they can put their dog. Many of them put their dog in there. They can put therapists. Any of the supports that they perceive as having around them, they will fill in there.

And then the second part of it is to create lines between themselves and each of those members of their social network, and in those lines, to find some of them are broken, so it's a more strained relationship. Some of them are solid, so a stronger relationship. And it just helps them to give us a picture, like a physical representation of what do they have around them in terms of social support and what is the nature of those relationships?

(11:00)

Q. And what was identified in terms of maybe an area of

concern in terms of Lionel Desmond's social network?

A. This ... it confirmed my impression that I had in our early meetings that he did have not a great social network or his perceived ... it's important to point out that this is his perception of his social network. He may well have had people around him who cared and who wanted to help him, but in his perception he didn't identify many ... any strong links with people around him.

Q. And is that something that was sort of of a concern when someone is going back at some point to their community, the lack of that support and social network?

A. It's something ... yes, it's something that ... and this is the reason that we do this particular ... the ecomap early on in the treatment is that it helps them to identify areas that they might be able to improve upon. Ideally, to create some more links and more ... before they leave. So it gives us ... it gives me, as a social worker, a picture of what their social network looks like, and it helps them ... for some of them, it helps ... like, Oh yeah, I have a lot more people than I thought I did, and for other people, it's more like, Ooh, I really don't have that much around me. So it gives them a starting point. So you try to improve that and solidify that.

Q. In terms of his continuity of care when he's leaving Ste. Anne's, what recommendations did you have about this concept that his social network was not as great as perhaps it could be?

A. We had ... I'd have to look at my list that I ... I had spoken to him about OSISS, about having ... OSISS being the peer support group. So I do feel having someone who had shared background experiences can be a good source of support, in addition to someone who's more of a therapist.

I had also mentioned having ... being a member of a cycling group and we talked about different things he could do with his family ...

Q. You said ...

A. ... as well.

Q. Sorry, I'm going to cut you off. You said, was it cycling group?

A. Cycling group. It was not random, exactly, but it was a recommendation that I made and I discussed with him because of the social isolation, in part, and also because of him having identified outdoor activity as being very therapeutic and very helpful for him. Socially, I felt it was a good option for him because doing an activity, sharing an activity, with someone

else is a great way to feel connected to them without having the pressure of having to have a conversation and having to ... you know, all the social niceties and the, How are you? You don't have to do that. If you're in a cycling group, you're together in a group without the pressure of having to be socially adequate and always know what to say.

Q. So it gave him an opportunity to function in a setting where maybe he didn't have to be as in the spotlight or interact maybe as much, but he's still getting some interaction?

A. Exactly, and getting that sense of belonging, and it sort of hits two birds with one stone. The social belonging as well as the leisure activity and the athletics thing that helped him so much and outdoor most of the time. So I felt it really hit a lot of areas that he'd identified as needing help with.

Q. And obviously, you're not a clinical case manager, but is that something that you had in mind that a clinical case manager could set up for him and say, You seem to be interested in this. What about this group?

A. To be honest, I'm not that familiar with what happens after they leave and who ... I know that VAC, the case manager at VAC, and the clinical team, they look at our recommendations ideally and try to find ways to implement them. Some of the

things that are on there would be something that he, himself, would've had to seek out, but in my understanding as the role of the clinical care manager, they would've been present to help him with that organization of ... Well, where do I find a cycling club and how do I get involved in that?

He also ... you know, I think he might've been capable of doing those things on his own had it ... you know, in a different ... perhaps if there weren't so much change at the same time then he might've been ... he had some of the skills to be able to do those things with a little bit of guidance but he was able to do some of it on his own.

Q. Okay. Page 244. You have a progress note from June 22nd, 2016. So we're about three weeks into the program and you have a conversation with his Veterans Affairs case manager and you have a follow-up with Lionel Desmond. What was happening here? What was the need for you to be speaking to the case manager and then coordinating things with Lionel Desmond?

A. There seemed to have been a miscommunication. Mr. Desmond had understood from an earlier conversation with his case manager that his wife would be able to visit him and that all of the costs of her visit would be reimbursed. He discovered through this case manager that that wasn't to be the

case, that the only situation where they would provide ... that they would reimburse a person for the trip is if it was something that we were ... that our program was requesting. And in this case, although we do normally have a family day at the end of a person's stay, this particular visit was something that he and his wife had chosen to do. It wasn't part of our program. So he was pretty upset that he wasn't going to be getting that reimbursement.

Q. So did you ...

A. So my reason for ...

Q. Go ahead.

A. Sorry. My reason for speaking to the case manager was just to make sure that I had all of the information that I needed.

Q. Did you get a sense, from speaking to the case manager, that the cost for having her and her daughter travel to Quebec while he was in the program was not going to be covered?

A. For that particular situation, the weekend that he wanted them to come, it was not going to be covered. She said that if we have ... and when we have ... we normally do have a family day, that that would be covered because it would be considered part of the program, part of the services that we

were offering, but not just a visit, just a family visit, without there being a clinical recommendation behind it.

Q. And clinically, did you see some value in having his family go to Quebec, his wife and daughter go to Quebec, because you identified at the outset, a goal of his interpersonal relationship with his wife and daughter as a primary focus. Did you see the value in having them visit him while he was at Ste. Anne's?

A. Yeah, I think so. I thought it was important for him to be able to see her and for them to have a chance to sit and talk face-to-face about what was going to be happening afterwards. Yes, I thought that was something that was good for him, yes.

Q. This concept that it wasn't going to be covered, did it appear to be pressing on his mind and causing him some stress and distraction?

A. He had a day, I'd say, where he was pretty angry about it. Angry more about ... I don't know that it was that he couldn't ... they couldn't afford it. More at the ... this is wrong because they said it was supposed to be this way and now they're changing. So there was anger that the situation, as he understood it, had changed. It did bother him, but in the end,

she decided to come regardless and he was okay with it in the ...

Q. Do you know, yourself ... and maybe you don't know the answer to this question, I just didn't want to leave it lingering. Do you know if it was ever covered or not?

A. I don't believe so, no.

Q. There's an indication ... and I appreciate a lot of it is sort of blacked out, it's been redacted, on page 244. So Lionel Desmond is also discussing some sort of conversation with someone where he talks about forgiving his wife and he didn't want to hear it anymore and he hung up the phone on this person.

A. Yeah, I believe the person that he was speaking to was the case manager and I think ... actually, I've read this and reread it and tried to remember what I had written under those blacked-out marks, but I think that perhaps the case manager may have suggested, Do you think that now is the time for her to visit when you're just getting some therapy and you've had conflicts with her in the past and maybe you should focus more on your therapy?

I could be totally off on this, but as I've been trying to remember, I think there may have been some comments saying, Are you sure it's a good idea for your wife to come right now? And

that he's ... as I said, that was his reaction, that he didn't want to think about it and that he wasn't angry at her and he wants to see her.

Q. So you got the sense ... your recollection is perhaps, the case manager was trying to discuss with him whether or not it was in his best interests to have her visit him?

A. Yeah, I think that may have been what the discussion was.

Q. Okay.

A. I'm not a hundred percent on that though.

Q. Sure. But ultimately, I guess, the person that would be best, or group of people that would be best suited to analyze whether or not her visit would be in his best interests would probably be the clinicians at the clinic?

A. Yeah. Well, and even then, I think it's something that would ... we wouldn't have been able to decide for him. It would've been something we'd collaboratively with him and what his goals were, and from what he was telling us at that time, it seems to make sense. They were ... he'd been with us for a few weeks. They were talking about reconciling. It seems to make sense that they have a chance to see each other and speak face-to-face and try to make a plan.

Q. Does Lionel Desmond make comments about he'll leave the program if this doesn't happen?

A. He did, yeah.

Q. So he was pretty firm in his desire to have her visit? Is that fair to say?

A. You're glitching a little bit there.

Q. Oh sorry.

A. The feed is not quite ...

Q. Can you hear me now fine?

A. I can hear you but you're frozen.

Q. Okay.

A. But go ahead. We'll see if I can ...

Q. Well, I'll just wait to see if it's fine on your end. If it's not, we'll probably stop.

A. Okay. It's clearing up. Go ahead.

Q. Perhaps, Your Honour, if we could maybe take a morning break at this point just to check to make sure that the feed is fine?

THE COURT: Well, I think one of the things we can do is just try and re-establish the connection and see if it makes any difference.

So, Ms. Hamilton, in a normal course of events, we often

take a break in the morning, sometime around 11:15, and we're close to that now. So we may just take the break now and see if we can maybe relink or allow the court staff here to figure out what the best thing to do is, but we may just try and link up with you again and then we'll come back.

A. Okay.

Q. Maybe 11:30 our time. I guess it'll be 10:30 your time. Thank you.

A. Okay, thank you very much, Your Honour.

COURT RECESSED (11:12 HRS)

COURT RESUMED (11:32 HRS)

THE COURT: Ms. Hamilton, can you hear and see us all right?

A. Yes, we can, Your Honour.

Q. All right, thank you. Mr. Russell?

MR. RUSSELL: Ms. Hamilton, so where we left off, it was at page 244 of the record and we were discussing Shanna Desmond coming to visit Lionel Desmond and whether or not that was going to be funded. This third paragraph on page 244 seems to indicate that he expressed to you that he was going to actually leave the program as a result of this, but someone might've encouraged him not to? Could you tell us a little bit about

that?

A. Yes. He mentioned that his frustration was such that he felt he was tempted just to go home, not completing the program, but that his wife encouraged him to finish.

Q. So from that, you gather she was somewhat supportive of him in his efforts to proceed in a health- ... get better, I guess.

A. Yes, very much so. She very much wanted him to take this time to work on himself and start to get better.

Q. If we could turn to page 246. 246 and 247 are progress notes entered by you on June 29th. This appears to be after Shanna Desmond's and Aaliyah Desmond's visit with Lionel Desmond in Quebec. And then you note that you wanted to, (1) discuss how the weekend went, but (2) to obtain authorization for the first time to speak to Shanna Desmond. Why did you want to now speak to Shanna Desmond?

A. At this time, this stage, and the ... first of all, we generally do try to speak with the spouse at some point in the program, during the time that the person is with us, just to get us a better picture of what's happening at home, what his or her concerns are for their partner. In this case, specifically, it had been prompted by the realization that I wasn't getting all

of the information about the dynamics, about what was happening within the relationship. That and I believe Dr. Ouellette had asked me specifically to call her.

So it's part of every treatment that I have with a client. I always contact their wife whenever they give me permission. And in this case, it was because ... it was additionally important because I felt I needed more information to understand what was going on in the family.

Q. Did he readily give that authorization to you to contact her?

A. Yes, he did.

Q. So how did he convey to you how the weekend ultimately went, the visit with his wife and daughter?

A. He was very vague. He said he found it difficult. It was hard. He repeated that statement several times. He said ... I asked him, What was hard about it? And he said, It was hard to say goodbye at the end, but when I asked, Well, what about the actual visit, the time you spent with them, it was still ... he was pretty evasive. He eventually said that he had asked his wife, he wanted to renew vows with her. And then again, he was evasive. He sort of went off on a few tangents, but finally said that she hadn't said yes right away, that she

put conditions on it. Do you want me to tell you what the conditions were?

Q. So before we get there, so did you get the sense that during this weekend that you say he found ... that weekend he found difficult, did you get the sense that that's when he asked her, Would you be agreeing to renew our vows?

A. Yes, during that weekend, yes.

Q. And so you got the understanding of ... the sense of ... how was the relationship from your understanding? How was it going at that point?

A. I don't think it was a terribly solid relationship. I don't think they spent a great deal of time together at that point. That's based on the little bit of information that he gave me and then also the information I got later on from his wife. Yeah, I do think they spent more time apart than together, and the time they did spend together after his missions, he was not doing so well, so there was a lot of walking on eggshells and there was a lot of repairing that needed to be done in the relationship.

Q. And you indicated that he conveyed to you that she put conditions on whether or not ... she would agree to renew the vows subject to certain conditions.

A. Mm-hmm.

Q. What were those conditions?

A. She had three. One was to apologize for something that apparently he had written, some post on Facebook, insulting things about her and her family. The second was that she felt he wasn't always honest with his doctor about complying with medication. There's a section here. Some of it's blacked out, but something about sharing medication, and then talk about his marijuana use. And then the next, the last one, was her payment of bills, that she wanted to take over the finances.

Q. So I guess if we break them down, did you get a sense of what it was that he was posting on Facebook about her and whether they were pleasant, I guess?

A. No. He acknowledged ... he didn't tell me in detail what they were, what he wrote, but he acknowledged that he had written some insulting things about her and her parents on Facebook.

Q. And, as well, she had concerns about him sharing his medication and to tell the truth about that. Did you get a sense of who he was sharing his medication with and what kind of medication it was?

A. I ... part of it's blacked out. I can't remember who

she said he was sharing it with. It may have been his father, but I hesitate to say that because I don't remember specifically. But the main thing, there was the sharing aspect, but there was also the non-compliance, that he would sometimes decide not to take his medication.

Q. Okay. And finally, this is where you indicated there was sort of a contradiction in the finances. He makes a comment to you. What was the contradiction?

A. It was the contradiction between the first statement that when I first met with him and he told me that he felt she was taking advantage of him and spending all of his money and not leaving him enough to pay his bills. And then in this conversation, he admitted that she actually did a really good job taking care of the finances and that he became quite overwhelmed and didn't feel able to manage finances on his own.

Q. Did he talk anything about his daughter in the context of the visit?

A. Yeah, a little bit. He didn't indicate that they had communicated very much. He said she spent most of the time playing games on a device of some kind. So he didn't really ... I got the impression that he really didn't speak to her very much during that visit.

(11:40)

Q. So what was his plan? He starts to discuss, I understand, a little bit about his plan of where he's going to go after he leaves Ste. Anne's. What was the initial sort of plan that he had in mind?

A. At this time, his plan had been to ... he wanted to move into the countryside with his wife and daughter in Nova Scotia. He wanted to buy a little house somewhere off the beaten track.

Q. And I understood that New Brunswick was a source of kind of some stress for him? What was that?

A. This is common for many veterans if they're living in a military town, so-to-speak, near a base, they'll hear the practice, the gunfire going off, they'll see people in uniform, they'll see military vehicles, tanks and whatnot, and there's too many visual triggers and sounds of their training or their missions, so they're often on high alert all the time.

Q. It's a result of this sort of, according to your note, this meeting where you note at the bottom of page 247, you say ... I guess the top. The last note at 247, "Follow-up". And you're going to contact Shanna Desmond at the request of Dr. Ouellette. And then you said: "To help determine any risk of

dangerosity."

A. Mm-hmm.

Q. So I wonder ...

A. Yes.

Q. I wonder what is "risk for dangerosity" and why is this coming about?

A. Risk of dangerosity essentially is evaluating the potential for aggression, for any kind of aggression. It came about specifically because Dr. Ouellette had had an interaction with Mr. Desmond wherein he felt he saw ... he felt a little bit concerned that perhaps Mr. Desmond could become violent, so he asked me to contact the wife and find out, from her perspective, what she ... if she had experienced any violence or if she ever felt that there was a fear of violence in the home.

Q. So from your understanding, it was sort of something that was generated from Dr. Ouellette that perhaps this is worth exploring. I noticed he was aggressive with me and I would like you to contact her.

A. Yes.

Q. Do you recall anything more about sort of what went into that prompt to reach out to her for that specific purpose of determining whether she was at any sort of risk for violence?

A. So the interaction between Dr. Ouellette and Mr. Desmond?

Q. Yes.

A. I recall, I believe it had something to do with medication he had prescribed, Dr. Ouellette had prescribed, that Mr. Desmond did not want to take and that Mr. Desmond became quite angry and verbally aggressive when Dr. Ouellette tried to work with him on convincing him to take this medication.

Q. And from your observations with Lionel Desmond at that point and knowing what you knew, was there anything else that would've factored into your decision to say, Yeah, you know what, I think it is a good idea to reach out to Shanna Desmond and discuss with her?

A. Well, I had definitely wanted to reach out to her to find ... get a clearer picture of what was happening, what she wanted from the relationship and, you know, what her expectations were. As far as the risk for violence, at that time, I hadn't seen anything that caused me concern. Maybe ... it was probably emotional regulation difficulties, which are not uncommon, and it's also typical for the family members to be walking on eggshells, but I wasn't specifically concerned about that aggressiveness (inaudible - audio).

THE COURT: I'm sorry, it caused you concern about? I just ... I didn't ...

A. Aggressiveness.

THE COURT: Sorry, the audio just kind of broke up a little bit on me here. I didn't quite hear what you said.

A. I didn't have ... personally, I didn't have any specific concern regarding aggression or violence at that time.

THE COURT: Thank you.

A. I was exploring that area on behalf of Dr. Ouellette. My primary ... my focus was just getting a bigger picture of what was going on with the couple.

THE COURT: Thank you.

MR. RUSSELL: If we could turn to page ... I may ...

THE COURT: Sorry, I ...

MR. RUSSELL: Sorry, Your Honour.

THE COURT: My question was did you follow up with Shanna and ask her, point-blank, about whether or not she had any concerns with regard to either aggressive or violent behaviour with regard to Cpl. Desmond?

A. Yes, I did, and the conversation with her that I had after this meeting with Mr. Desmond, I did specifically ... she had a lot of information to share of concerns she had and I

specifically said, Do you ever feel that you're ... that you could get hurt or that you're unsafe? And she, at that time, said she did not feel he would ever hurt herself or her child.

THE COURT: Thank you.

A. You're welcome.

MR. RUSSELL: If we could turn to Exhibit 255.

A. Which page number is that, sorry? 250- ...

Q. I'm just going to double-check once the court brings it up.

It was a document ... Ms. Hamilton, it was your report from June 30th of 2016. It was regarding a conversation you had with Shanna Desmond as a result of Dr. Ouellette's request that you follow up with her.

A. Yes, I have it, thank you.

Q. So I just ... I guess, starting on the first page. So this is the notes you made as a result of the conversation you have with Shanna Desmond?

A. Yes.

Q. And do you recall when this conversation was?

A. It would've been shortly after my conversation with Mr. Desmond.

Q. Did Shanna Desmond seem receptive to the idea that you

were reaching out to her?

A. Very much so, yes. I think she ... I mean I believe we spoke for over an hour in this conversation. She had been wanting to speak to somebody for some time.

Q. Did she express to you that in the past, she had maybe been taken off contact lists as it relates to different health care workers with Lionel Desmond?

A. She did. She said at some point he, Mr. Desmond, removed her name from the list of people that the OSI team in New Brunswick was authorized to speak to, so she could no longer communicate with them and she found that very difficult because she knew that the ... well, she believed the information they were getting from him was not completely ... was not everything that was going on.

Q. Did you find that the information you received from Shanna Desmond during this hour phone call was very helpful?

A. It was very helpful. She was very articulate, very able to express things. You could tell she had her medical training, so she was able to name all of the things very clearly that she had difficulties with and that she wanted ... she thought would be important for us to focus on in the treatment.

Q. So we're going to review them and I think it's

important to review them one by one because you sort of set them out very concisely in your report. I guess on the third paragraph of the first page, she first ... she describes him as a completely different person since the time he was ... since he returned back from his missions. Did she elaborate on that? Did you get a sense of what made him a completely different person?

A. Well, she elaborated on the differences and she felt that it was something that occurred in his missions that caused that change. The differences being that, she said when they first started dating in high school, he was very happy, very active, very social, and that when he came back, he was very reactive, easily angered, very tense. Just not behaving in the same way that he had prior to his missions.

Q. Did she indicate to you how their daughter, Aaliyah, had sort of reacted to him in the household?

A. Yes. She said that her daughter would become quite upset if he started yelling or making a lot of noise. The non- ... the verbal expressions of anger.

Q. You noted in your report - it's the fourth paragraph down and it has three little stars by it on the left side - you say: "Also to note that her daughter is frightened when he

yells, but that he has never been physically violent towards either of them and she has never felt that he would hurt them." Do you recall Shanna Desmond indicating that to you?

A. Yes.

Q. Did you get any sense of whether or not she was perhaps downplaying whether or not she probably was a risk or did you think that she was being very candid and forthright with how she perceived things?

(11:50)

A. I really felt that she was being very forthright, very, very honest, and in conversations afterwards, she never hid anything. She was always very authentic in her concerns, so I believe that she believed this at that time.

Q. And did you sort of ... on your end of things and mindful of the fact that the purpose of this call has a number of purposes, but one of them is to sort of really get a sense of, is she at risk for violence and is her daughter at risk for violence, did you sort of explore that a little bit to really satisfy yourself as to whether or not she believed that there was a risk?

A. Yeah. The exploration took in the form of asking her different examples of what they were experiencing in the home.

So the unpredictability, the mood swings. I asked her to describe what those mood swings would look like, what it looked like when he flew off the handle, and that's where she discusses the two episodes where he had thrown furniture around, and that was the extent, that was the most violent he had ever been that she had been witness to. So we really explored all the ... his different forms of expressing his anger and none of them were ever physical towards her.

Q. So I guess if we start with what you indicated. Number one, you said "anger issues". I'm wondering if you could tell us what you had noted there from your discussion with her as it related to anger issues.

A. Yes. She mentioned the two incidents. The first, that she arrived ... I think this was at his apartment in New Brunswick. He'd come home from work or something and he was in what she would've described as a rage, that he was throwing his drawers around the room but she didn't know why and he wasn't able to tell her why. And that sometime ... he left and sometime later came back and had ... and was feeling better.

Q. You described in number one, you said: "Many triggers. Don't know what they are, therefore, unpredictable angry episodes." Did you get that sense from her that his anger was

very unpredictable?

A. Yes, very much unpredictable, and she described, she gave an example of, there was an incident where their daughter scratched his car with a toy or something and his response was very, Oh, don't worry about it. It's just a car. It doesn't matter. But then if she spilled a glass of water on the floor, that might trigger him to fly into a screaming rage.

Q. And you also noted under number one, you said: "Impossible not to trigger him. Unpredictable." Are those her words?

A. I believe those are her words, yes (inaudible - audio).

Q. What sense did you get from her when she said, It's impossible not to trigger him. What did you understand that to be?

A. It really highlighted - and, again, this is very common amongst many of our clients - what many spouses talk about is the walking on eggshells because you just don't know what might set somebody off. It could be something tiny, it could be something bigger. You just never know, so you end up very carefully walking on those eggshells trying not to trigger them, but the reality is that it's not possible not to trigger them because it's not the spouse's fault, it's the person, whatever mindset

they're in on that day. However, they can push their limits by a variety of other stressors. It could be just water falling on the floor that tips them over the edge. So that was really ... I saw it as being something that's very common and I know it ... and highlighted that with her that this is common, it's something that we can work on in the program.

Q. Did you get a sense that it was very ... how frequent it was? It's not sort of ... whether it's a one-off, once in a while or very frequent when she says, He's unpredictable and it's impossible not to trigger him. Did you get a sense of how frequent that was?

A. No, I didn't get a sense of that. I don't recall there being an idea of how often it was. She didn't specifically say, This is every single day. I may or may not have asked that, but she didn't say that this is something that happens all the time, just that they have to be careful because he's unpredictable.

Q. The next line you note in your report under number one, you said: "Won't let daughter stay alone with him."

A. Mm-hmm.

Q. Did she come right out and tell you that she does not want Aaliyah to be alone with her father?

A. She did and she explained that it was because of the

unpredictability and because her daughter would be so upset by if he started yelling. She didn't want her to experience that. She wanted to be there so that if she had to run interference, she could do so.

Q. So did you get the sense that she was worried that something may physically happen to her daughter, or what was she worried about that she clearly didn't want her daughter to be alone with Lionel Desmond?

A. My understanding at the time, from what she was saying, was that it was more not wanting her to have that anxiety and her daughter to experience that anxiety and stress and be scared but not that she was afraid he would hurt her.

Q. And number three at the bottom of page one, she described, and it's in quotes, "manic episodes and impulsiveness". What examples did she use about what she described, in her language, "manic episodes and impulsiveness"?

A. She described mostly financial things like spending a great deal of money. It's written here, "$4,000 snowblower for a very, very small front driveway, a power saw". And then sort of buying all those things that weren't really needed and then giving them away, and she speculated that perhaps he was doing it because he regrets having made the purchase or sometimes she

thought it was in retal- ... it was some kind of an anger against her.

Q. If we turn to page two, what do you document here as another concern that she relayed to you about Lionel Desmond?

A. In the number four? It's that he would become obsessed with a small slight, so something someone said or did that he was offended by and become ... and focus exclusively on that and being unable to talk about other things or to let it go.

Q. She mentioned something along the lines, If you call him, it's one way, and if you don't call him, it's another way. What was that all about?

A. Yeah, I'm trying to ... I'm not seeing, actually, as I read the note how that particular statement fits with the previous one about being obsessed with a small slight, but I think it relates in the sense that he did have this view of people not being there for him, and so his tendency ... the lens through which he interpreted things tended to be the lens of, You don't care about me. So if she called, then he would accuse her of being intrusive and, You don't need to call and everything is fine, but if she didn't call, then he would accuse her of not caring.

Q. Sort of this kind of impossible scenario, no matter

what she does. If she calls, it's a problem; if she doesn't call, it's a problem.

A. Yes, because underneath it all, he had this very consistent fear of abandonment and that's how ... this is my personal view, not a clinical view, but I believe that that was something that was underlying and it probably slanted his perspective, his way of viewing things.

Q. And I understand, on the fifth point, Shanna Desmond, on her own initiative, decides to weigh in on what she perceived as a risk for suicide.

A. She identified ... I wrote "suicide risk" here. She identified it more as passive threats. She felt that ... well I mean he would text her comments, My daughter ... tell my daughter I'll be watching her. And she would come home and find him maybe cleaning his gun, but he would deny that there was ever any risk, he never had any plan. So, at the time, we talked ... she talked about it more in the context of he threatened suicide as a way of controlling me.

Q. So she described a situation where he would text her and say, Tell my daughter I'll be watching her from above and she would come home and then find him cleaning his gun?

A. Yes, but that he would deny any ... that there was ever

any risk or any intention, that his statement didn't mean anything.

Q. Did she find that concerning?

A. She really felt it was more ... I asked that. Do you think that he was going to follow through on it or he had intentions to follow through on it? And she didn't feel he did. She really felt it was more about him testing to see if she would come home and, again, more of that fear of abandonment. If I do this, is she going to come and check on me?

Q. This particular aspect is fairly, I'll admit, pretty substantial that he openly says, Tell my daughter I'll be watching her from above, which she interprets as he's going to do something to himself perhaps. And then it's followed up with she encounters him cleaning his gun. What did you make of that?

(12:00)

A. Well, at the time, it didn't ... it was something that we certainly opened up with him. I think ... it wasn't in one of my notes, but someone would've discussed it with him. I saw it more as fitting into his need to reassure himself that she would come home, and I say that because it fits with some of the profile that Dr. Gagnon and Dr. Ouellette have come up with of maybe having mixed personality traits, and among those traits, if

there's borderline personality traits, one of those ... so that fear of abandonment moves you to go to extreme lengths to prove that someone ... to prove to yourself, Do they ... Are they going to abandon me or are they going to take care of me? So it's a difficult ... it's an extremely delicate and difficult thing for any clinician to comment on. If someone is sitting there cleaning their gun, who am I to say, Well, no, there's no risk? But it is part of the profile where there would be many passive suicide threats that occur and, ultimately, the person does not follow through because the underlying need is to be shown that people are going to come and take care of them.

Q. Okay. And number six, you discussed obsessive texting. She relayed to you information about obsessive texting. What was that?

A. Yeah, that she would go to work and then a few hours later on her break, she'd find 400 texts. We talked about that as terms of part of his obsessiveness and I don't remember to what detail we discussed that. It was just one of the behaviours that she wanted us to address.

Q. Did she describe the nature of these texts? Were they "I love you" or were they opposite maybe of that?

A. Yeah, she described them as being nasty.

Q. Did she describe what she meant? I mean, 400 nasty texts. Did she ... or upwards of 400 nasty texts. Did she describe the content of these texts and what they were?

A. I don't recall in detail what she said. She may have given me more details, but I don't recall what they were, just that they were not kind.

Q. And did she say that this was ... did you get a sense that this obsessive texting was just here and there or was it with some frequency?

A. I think it happened more than once. I don't know that it was a daily thing by any ... but I believe that it was something that had occurred on more than one occasion.

Q. Number seven, you outlined, it was under "Meds". Now, I appreciate this is her saying it and it's not a clinical diagnosis, but in her terms, she was saying he's bipolar. And I appreciate that she is a mental health nurse. She has some insight into maybe some of the struggles he was undergoing, but he was never diagnosed with bipolar. But she described him as having bipolar disorder. What did she describe to you?

A. She ... this was where she described the impulsive spending and some of the mood swings. So that was her primary concern. That was what led to believe that he might have bipolar

disorder was the mood swings and the impulsiveness. However, there's a lot of overlap, you know, personality ... bipolar personality disorder with ... sorry, borderline personality disorder with bipolar, there's a lot of overlap in those symptoms, so what she was seeing could fall into bipolar disorder, but it could also very easily fall into borderline personality disorder or there's even other things too. There's so much overlap in all those different areas.

Q. And she indicated that at points, he would stop taking his medications?

A. She did say that he was sometimes non-compliant with his medication, yes.

Q. Did she say why he would stop taking? Would he offer an explanation for why he stopped?

A. I think ... what did she say? Sometimes I remember there being one medication that was an antipsychotic medication that he took ... accept ... he didn't even want to accept taking a medication that was used for ... as an antipsychotic, so that offended him, I think. He didn't feel that he needed it. Other times, she said he was just looking for reasons to stop, like, he'd say that, Well, this one stops me from remembering my dreams which this isn't normal, so maybe I should stop.

So my own perspective on this is that Mr. Desmond was someone who took very good care of his body. He felt very strongly about eating well, doing exercise, being healthy, and so he had his reservations about taking medication and the impact that that could have on his physical health.

Q. And you talked about using ... number eight was, "She relayed using words she doesn't understand." What was an example? What was she saying there?

A. This one, she used the word "harassment" as an example, that he would use the word "harassment" when someone ... his case manager called him twice, but then if he called her many, many times, he didn't understand that that ... he wouldn't use that word in the same way. But I believe there may have been other examples, but she did feel that, in his language, there was something ... sometimes he was mixing up words or not using quite the right expression for a situation.

Q. And number nine, it says: "OCD washing gun obsessively, but never been used." So she relays that information to you?

A. Yes.

Q. Did she say how frequently he would in the context ... Because what I gather from that is he's obsessive in washing ...

in taking out his gun and washing it.

A. Mm-hmm.

Q. Did she describe to you how frequent it was that he would take out his gun and shine it up?

A. No, she did not. When I ... I'm trying to remember. I think it was more that when he got it out, he would wash it extremely thoroughly. That's where the obsessive ... he might take hours to clean every single little piece and get it back together. I didn't get the sense that it was done frequently, more that when it was done, it was done extremely thoroughly.

Q. Okay. She talked about sort of flashbacks, she relayed to you in number ten. What sort of an example of sort of conduct that he would have all of a sudden if he had a flashback at home?

A. In this one story that she ... the incident she told me about, it was very hot out and I'm assuming the heat triggered a flashback to Afghanistan, so she said he became very angry. He hit the top of the car hard enough to make a dent in it, was crying, yelling, Hot, hot, hot, and he went to the basement and lay on the floor naked in order to cool down. And when he did come out of it, he told her he felt like he had ... he was back in Afghanistan.

Q. Number 11. Did she comment about his tolerance for

noise?

A. Yeah, that he had difficulty tolerating it. He found it overstimulating.

Q. And I guess number 12, you noted again that she again relayed the concerns that by being taken off the authorization was that the treating therapist couldn't understand or know what his most current obsession was?

A. Yeah, that that's all ... that he would show up and only talk about whatever his current ... what did she call it, his current obsession. So if he had somebody he was angry at, that he would spend the entire session talking about that one incident, but that they wouldn't hear about everything else that's going on.

Q. In terms of ... she relayed about financial stress and how he would sort of manage the bills. Did she give a sense of how well he was doing at that?

A. She felt that he became overwhelmed and that he didn't always understand. He'd get a bill and he wouldn't seem to read it through or understand fully what it meant and he would react sort of impulsively and paying three ... one example was paying three months at once and then emptying his account and not having enough money left to pay other bills because he wasn't ... he

would be reacting. Get a bill, he'd get strapped, and so he'd go and pay everything off but then not be able to organize it and understand to pay things slowly in order to have enough money throughout the month.

Q. And number 14, she sort of discloses that there's some maybe perhaps inconsistency of what he may be telling his case manager from Veterans Affairs that might be contrary to what the reality is?

A. Yeah. She described a situation where he had been away for several months and when his case manager - I don't know if it was his VAC ... could've been VAC case manager - came to visit, he told her he hadn't been eating, he didn't have enough money, and he showed her all these empty ... the fridge and cupboards as proof that he didn't have enough money to buy food, but he didn't mention that he had been away for three months, so ... and he just hadn't gone grocery shopping yet. So she felt sometimes he was misleading in the information he did give.

Q. Number 15, she talks about what you described as "other impulsive behaviour". What's an example that she disclosed to you about his impulsive behaviour?

(12:10)

A. That he at one point called her saying, Take the house

off the market. I'm going to go bankrupt and go live in the woods. So I assume that was reactive to perhaps the stress of trying to sell the house. Perhaps it wasn't selling as quickly as he would've liked it to, and that that was his reaction to that.

Q. So did she disclose to you that he told her that he would go live in the woods?

A. That was in that conversation that he called her, yes.

Q. Was there ever any sense from her whether, in fact, he ever did go live in the woods, or no?

A. No.

Q. Number 16 is she describes to you much like he has described to almost every health care clinician he's encountered about nightmares. What did she describe to you about nightmares that he was having?

A. She described that he was having a nightmare ... he had been having a nightmare that recurred that he discovers her with another man in their bed and that he kills her ...

Q. And in quotes ...

A. ... in that note.

Q. In quotes, it says "chops her to pieces". Is that her words?

A. Those are her words, yes.

Q. So it's pretty descriptive and graphic, the nightmare.

A. Yes.

Q. Did she indicate that she had any concerns that he, in his words, relaying a dream to her that she's being ... engaged in an affair and he chops her to pieces? Did she convey to you any concern about what in the world is going on?

A. The way I remember it, she was concerned by it. It's not a pleasant thing to hear. She felt that it stemmed from his insecurity and his feelings he wasn't sure that she was being faithful. She didn't indicate that she felt he would follow through, mainly because the concept of him sharing this with her was not in a threatening way, it was in a ... he was very upset by the fact that he was having this dream. It was not, you know, This is what I'm going to do to you if ever you leave me. It was a case of, I'm really having these horrible, violent nightmares and you're involved. He was sharing with her. So she didn't ... she was upset by it because, obviously, it was upsetting to him, but she didn't indicate that she felt there was a risk of him living out this nightmare.

Q. In terms of your impressions, so if you could tell us what your impressions were of this 60-minute conversation with

Shanna Desmond.

A. I recall being very impressed. My impressions were that I was very impressed with Mr. Desmond's wife. She was very credible. She seemed to be able to ... while she was emotional in her expression of what was going on, she also seemed to be quite objective in her ability to describe some of the behaviours. She seemed to genuinely want him to get help and to work on their relationship and she seemed, you know, concerned for him, for his well-being.

Q. Did you seem to ... I guess some of the stuff that she's telling you, did you sort of see examples of that in your time with Lionel Desmond? Did it seem to corroborate what was going on?

A. I'm going to go through them one by ... there were ... there are a few things that overlapped. You know, as you've seen in all of our notes, the anger issues, the unpredictability. Much of like this, in general, was something that we dealt with throughout the entire stay. We did not see any issues, any point where he was throwing objects or was violent in a physical sense. The impulsiveness, we didn't see very much impulsiveness on the unit, particularly, other than, you know, occasionally he'd have that impulse to leave in response to being disappointed or

frustrated, but he never followed through on that. The obsession for sure. There were certain situations where he would become very focussed on something and would have difficulty, as we noted in an earlier note, he would have difficulty letting go of something that had upset him. Suicide, our nurses evaluate daily for suicide risk and it was never something that was identified as a risk. The texting, that's very specific to her. Medication, he did ... he responded very well to the medication prescriptions up until the point where there was one last medication that Dr. Ouellette wanted to prescribe that he refused to take but, otherwise, he seemed fairly accepting of taking the medication that was prescribed.

We did recall, and I can't remember any specific details, but I do recall thinking, as far as language, the section where it talks about words he doesn't understand, I had remembered observing that sometimes he would use expressions that didn't ... rather than answer a question, he would answer with a vague expression, so the flow ... I can't think specifically what it was, but sometimes the expression that he would use didn't really fit with the conversation that we were having at the time. He did not have any flashbacks while he was with us, he did not appear to react strongly to noise, however, it's a relatively

quiet unit, and he was very open to us communicating with her throughout his stay. As far as finances, that was something that he discussed quite a bit, but he was ... had some resentment that he paid for her to go to school.

Q. So, I guess, one, you felt that she was credible and, in fact, what she was conveying to you was pretty consistent on a number of levels as to what the clinicians were observing while at Ste. Anne's.

A. Yes.

Q. I'm mindful of the fact that Lionel Desmond is your client and I'm sort of asking the question because I don't know the answer. Lionel Desmond is your client, however, you spoke to Shanna Desmond with his permission. Shanna Desmond describes to you what clearly do seem to be suicidal thoughts that he has in a context of, as it related to him, coming home, finding him with a gun. She describes to you that he describes to her he's going to chop her to pieces in a dream about her infidelity. She describes a number of things. She doesn't want to leave her daughter alone with him. She describes a number of things to you that she says are of concern. Is there any resource or thing that you can say to her, Perhaps it's maybe in your best interest to maybe reach out to someone or if you're having difficulty in

sort of understanding what's going on, this is what's available to you?

A. That's certainly something I would likely have said in the course of this conversation. In fact, OSISS, the organization that provides peer support for veterans, they also have peer support for spouses of veterans or for family members of veterans. So it's likely that's something I would've suggested to her to make sure ... it's something we always are mindful of, that the caregiver, the person who ... she wasn't his caregiver, but the person who is going to be receiving him when he ... they return home, that they need to take care of themselves as well. So we often give them suggestions such as OSISS or having their own support. And, in fact, VAC, one of their programs is they will pay for psychological support for the spouse of a veteran when it's deemed necessary. So this is all information that I would have shared with her, yes.

Q. You would've shared that information with her?

A. Mm-hmm, yes.

Q. This particular report seems to heavily emphasize things, and I know Lionel Desmond is your client and the client of Ste. Anne's, but there is the overlap that this information pertains to her and concerns she has, but we know that this never

gets passed on to anyone. We know that Veterans Affairs never gets it. We know that OSI New Brunswick never gets it.

Do you think ... and I know hindsight is something easy to talk about, I guess, but would it have been helpful to coordinate those peer supports and family supports if they had have really known the full extent of what she was struggling with, that was documented here in 16 very clear points?

A. Yeah, it's very ... I mean, the simple answer is yes, yes, it would be helpful for her to have the extra supports. At the time that this information was gathered, the conclusion is that all of this and our observations was that, yes, there were some issues within the couple, but that there was no imminent risk. We didn't assess there being a danger. So the suggesting that she get support, that was ... that was included. Would it have been helpful if they'd had this note? Maybe. I can't really say for sure. It certainly wouldn't have hurt, but, again, as to remember the context in which we received the information was without knowing what happened ... what has happened, so it doesn't have the same weight at this time as it does now.

(12:20)

Q. That's fair. And my other question is, we've heard

repeatedly throughout this, and I'm thinking back to Dr. Rahman who was the ER physician, sort of the last ... one of the very last, health care professionals to interact with Lionel Desmond. And we've heard discussions about how confident Shanna Desmond appeared to be. She would show up at different appointments, she seemed very in control, she was a mental health nurse so she would have extra insight than the average person. Is it possible ... and, again, I'm asking you because I don't know. Is it possible that a clinician can put maybe too much emphasis on appearances? Sort of, we all have biases in the sense of, Well, she attends his appointments. She's the one doing most of the talking. She's competent. She's a mental health nurse. Is there a possibility that we put too much emphasis on that when we're trying to really determine risk, I guess?

A. It is ... yeah, I'm sure it is possible. You know, I didn't know Mrs. Desmond personally, only in the conversations that I had with her. I got the impression that really, if she had something to say, to tell us, that she was worried about, she would've said it. I don't think she would've chosen not to share information in order to protect an image or to come across as competent. I ... that wasn't my impression of her.

Q. And, again, and I want to be very fair to you. I mean,

it's easy to look back in hindsight at these things and we're just asking questions to try to find information.

A. Mm-hmm. I understand.

Q. It's now 20 after 12, Your Honour. I think that seems to be a logical stopping point.

THE COURT: All right. Thank you, Mr. Russell.

Ms. Hamilton, I think what we'll do is that ... we would normally break here a 12:30 and we're approaching that time, so I think what we will do is we'll take our lunch break, normal afternoon lunch break, now and return in approximately an hour's time. If we could reconvene at ... be 1:30 ... be 12:30 your time, if that would be convenient?

A. That would be convenient, thank you.

Q. All right. We appreciate your time. Thank you, Ms. Hamilton. We'll adjourn till ...

A. Thank you.

Q. We'll adjourn till 1:30 then.

COURT ADJOURNED (12:22 HRS)

COURT RESUMED (13:37 HRS.)

THE COURT: Thank you. Mr. Russell, would you like to continue?

MR. RUSSELL: Good afternoon again, ma'am ... or good

afternoon, Ms. Hamilton.

A. Good afternoon.

Q. So I'm wondering if we could turn to page 258 of your report. Ultimately 258 of the Ste. Anne's record. So I understand at the end of July - July 26th, 2016 - you have a meeting between yourself, Ms. Royer, and Lionel Desmond regarding an incident between Lionel Desmond and a member of the nursing staff.

A. Yes.

Q. Could you tell us a little bit about what was the conflict between Lionel Desmond and the nursing staff member?

A. This was a situation where Mr. Desmond went to get his medication from the nurse and the nurse couldn't locate the medication. So he suggested that perhaps one of the other nurses had brought the medication to Mr. Desmond's room and asked him to go and check. But he asked them to check and then when he came back and said it wasn't there I think he was sent, from my recollection and from what's written here ... Mr. Desmond was sent two or three times to return to this nurse to check again, even though he knew that his medication was not there, and he became increasingly frustrated that he was being told to continuously check when he knew that the medication wasn't there.

And eventually, it was located and he got his medication. But in the meantime he became quite angry and agitated.

Q. And did this ... did Lionel Desmond seem to appreciate ... did he ... was he able to sort of identify a way of sort of dealing with this situation that was productive?

A. At the time his primary strategy was just to walk away and avoid interaction with the nurse after that incident. He didn't seem able to access some of the strategies that we had spoken about in the weeks previous.

Q. And I understand that he was even activated, I guess, when he was relaying this information to you, when he was telling you about the encounter. What were some of the observations you made of him?

A. That he ... yeah, I have it all. He was physically agitated. He was ... his voice was raised. There was a lot of tension, physical tension, finger-pointing, some swearing, rapid speech. A lot of physical signs that he was ... of his anger.

(13:40)

Q. You noted on page 258, you said: "Clenched jaw, raised tone, swearing, trembling, and finger-pointing." Who was he pointing his finger at when he was relaying this information?

A. It wasn't toward either myself or Madame Royer. It

was, I think, as he was discussing it he was pointing it as if the nurse was in front of him.

Q. And there was some suggestion. We heard a little bit about the strategy that ... the use of a coping card and how it didn't work so well with Lionel Desmond. The very mention of the coping card ... I believe he had a reaction to that? What was the reaction?

A. Yes, he did. Well, he seemed to get more agitated as, you know ... it was brought up, I think, twice, possibly three times. I don't know. And each time he became more defensive and, I don't want to use the stupid coping card. Something along those lines.

In retrospect, I think that two things occurred there. One is that we do know in anger management that the more intense a person's emotions is, the less they are able to access their strategies. Which is why we try to ask people to practice using their anger management strategies before they become very, very angry, that they keep ... it's a thermometer, that if they start to feel angry at, let's say, three or four or five out of ten that that's when they need to put in the strategies. Because once they get to seven or eight it's too ... they're too activated to be able to assess those strategies.

So that's one reason I don't think that ...

Q. Go ahead, sorry.

A. Well, I think that's one reason it didn't work, and the second reason is ... and this is common with many, many veterans that have anger management problems is that they separate situations where, I have a right to be angry here because I'm right and the other person is wrong, therefore, I have a right to express my anger in whatever way I choose versus I was wrong to be angry, I actually misinterpreted, so I should have behaved better.

So in this situation because he felt he was right, that he was justified in his anger, he didn't feel he should have to manage his anger in using those strategies. And us suggesting that he should, I think, may have been interpreted as accusing that, you know ... that, This is partly your fault, or that, You're not right to be angry, therefore, you need to manage your anger differently.

Q. So we're two weeks away approximately from his eventual discharge from the program. Is it clinically sort of concerning that he's still having an inability to, one, have insight into how his own conduct affects others but also having difficulty in regulating his emotions?

A. It's concerning ... it concerns what we had already observed, that his progress was going to be ongoing, that the anger management was not resolving ... emotional regulation was not resolved, that he was ... he made some progress but not a huge amount and that he would need to keep working on it.

Q. You indicate at the bottom of your report, you said that he stated clearly that he was aware that the nurse was afraid of him, that security had to be called. So he acknowledged that?

A. Yes.

Q. And what was his sort of response to sort of ... he relays that, I know the nurse was afraid of me, I know security had to be called. But then what's his interpretation of it? What's his attitude toward that?

A. He ... I think he didn't want to take responsibility for that. He said, It's not my problem, it's his problem, essentially. I didn't make him scared, he's making himself scared.

Q. And does he go further - I guess in your notes at page 259 - that if he has to deal with the nurse again what's going to happen? Does he sort of talk about it?

A. Yeah, he alluded ... he mentioned, I'll snap. Which to

me was a bit ... that was a concerning way of putting it. So we did explore what would that look like if you were to snap? And he said he would ... he might start breaking things. And I delved deeper asking, Would you ... do you feel that you are at risk of causing ... of lashing out physically at this nurse? And he said, No.

Q. And then later on he sort of gives this, I guess, ultimatum that if he has to deal with this nurse again ... what does he indicate is going to happen?

A. He suggests that if he is forced to work with this nurse he'll leave the program.

Q. So this is the second time, I guess, in about a month that he's said, you know, If not this, I will leave. First is in the context ...

A. Mmm.

Q. ... of if Shanna Desmond's funding isn't paid for to go visit him he's going to leave. Again, if he has to deal with this nurse he's going to leave. What do you think is sort of accounting for this resorting to, I'm going to give up on treatment if I don't get my way?

A. There's a variety of reasons and it's also something else that's not uncommon that we see with the people that come

through our program, that when they're frustrated and they're unhappy with something that they will often resort to that threat that they were going to leave.

So there's a couple of different explanations for that. One of them is when someone does have an underlying fear of abandonment they will often seek out ways to prove ... find proof that people actually want them to hang around. So by threatening to leave, they might get the response of, No, why don't you stay, I think it's good, and that answer sort of meets the need that they have.

So there's that and then there's also ... it's just a natural defensive mechanism. If someone is feeling vulnerable, frustrated ... they don't have a lot of control in that program. It's not their space. It's not their ... it's not their home. So the only way to regain control at that point is to leave the program and no longer have to be in someone else's environment.

Q. And in ...

A. So I don't ...

Q. Sorry, go ahead.

A. Sorry. I don't think it spoke to him necessarily wanting ... even to be giving up or wanting to leave. I think it was more of a defensive reaction.

Q. So it was sort of his way of sort of, as you indicated, maybe regaining some control over his affairs?

A. Yes, I believe so. Regaining control and getting the encouragement that he's wanted.

Q. Okay. If we turn to page 254. Again we're in July. We're at July 29th. I understand that in this progress note there's some discussion about Lionel Desmond and the sale of the house, his house in New Brunswick, and how he's feeling about it. What information does he share with you and the impact it's having on his relationship with Shanna Desmond?

A. He talks about ... yeah, he referred to his wife encouraging him to stay in the program and that she expected him to keep working and get better, that she didn't want to remain in the relationship if he wasn't continuing to work on his recovery, and at which point he called her his probation officer.

Q. How did he sort of ... did you get a sense of how he really felt about Shanna putting to him that, If you don't complete this program it's over, we're not going to be together?

A. Well, I think it hit a very ... a sore button for him. It was kind of his underlying fears and it definitely ... he felt hurt. I believe he didn't express at this time a lot of anger other than ... I guess the probation officer comment could be

construed that way. But mostly he seemed to feel hurt by this, that he was being made to do things in order to be accepted into her life.

Q. He seems to have sort of expressed to you this sort of crystallized idea of what would happen if things didn't work out between him and his wife. What does he say? If the relationship doesn't work between him and Shanna Desmond what's the result?

A. We ... he talked about just being very, very upset and he wasn't sure how he would handle it. Trying to find the specific paragraph where she mentions that.

Q. If you look at the third paragraph at the last line it talks about being betrayed ... feeling betrayed.

A. Right. Yes, that he would ... yeah, he would feel betrayed and that it would mean that she had used him to pay for her schooling.

Q. What are you making out of this sort of he equates one with the other? Basically, if she doesn't kind of work things out with him it will confirm that she's taking ...

A. Yeah.

Q. ... advantage of him. What's accounting for this?

A. I think that's again viewing things and situations through the lens of a therapy trail. And it's also part of that

black-and-white way of thinking that, Either you accept me as I am and everything works out, or you never loved me and you were just using me and you're a terrible person. It's in that dichotomy that people of this profile often have of, It's all black or all white.

Q. So we're two weeks before he leaves and based on what we've discussed in your report so far is it fair to say that the majority of your encounters with Lionel Desmond are all related to the relationship with his wife and the stressors?

(13:50)

A. I don't know that it would be the majority. I don't know that it would be the majority of my interventions because a lot of my interventions surrounded other issues that were occurring in the unit that ... many of them were surrounding what his plans were with his family.

Q. Would you say that the majority involved some sort of interpersonal conflict, whether it was his wife, a nurse, another resident, dealing with other people?

A. That was a recurring theme, yes, that there was interpersonal conflict, yes.

Q. And I believe he sort of discloses to you on this occasion some aspects of infidelity on his end of things?

A. Yes.

Q. What does he tell you about that?

A. He told me that when he was on missions he had affairs with two different women, I believe it was, and he doesn't ... he's not able to explain why it happened or why he did it.

Q. Did ...

A. He just ... he says he envied his colleagues who were single.

Q. Did he seem to be bothered by that? Was that something that was troubling him and on his mind or ...

A. He didn't ... at the time did not seem overly upset about it. He just sort of told me about it, said it was something that happened. He didn't know why, but he didn't indicate that it was something that weighed heavily on him.

Q. If we could turn to page 260. I understand that this is again the end of July ... July 29th. So you start to turn your attention to the upcoming discharge that at some point ... at some point he's going to go back into the community.

A. Yes.

Q. What is sort of your purpose of this ... these more recent interactions with Lionel Desmond? What are you trying to accomplish here?

A. This is part of discharge planning. We always try to work on it with the clients at least two to three weeks before they leave the program, and it's related to what we discussed earlier, the importance of preparing for that transition and making sure that they've got a plan in place that will help ease that transition and make it less of a shock.

Q. What was his immediate plan? Does he articulate to you what his plan is when he leaves Ste. Anne's? Where is he going to go? Where is he going to live?

A. He had a very clear plan. He'd already ... he sold his house. He had plans to be flying to Oromocto to get his ... to be discharged. After his discharge he was going to pick up his items that were in storage that I believe Shanna had organized for him and then drive to Nova Scotia to be with his wife and to live with ... I believe to live with her and her parents.

Q. And you have some sort of discussion with him about, I guess, the viability of that plan and whether maybe it's the best plan. Tell us a little bit about that discussion. Why did it come up and what did you try to discuss with him?

A. Well, yes, we did ... I felt ... I personally did not think that it was the best decision to plan all of that change all at once. Most people don't like change, particularly, even

good changes, but doing all of those changes - moving province, moving homes, moving in, taking on a role that he'd never had before - it was a great deal of change at a time in his life when he still had ... he had a lot of other stuff he needed to be working on.

And so the relationship as well, they hadn't lived together in some time and I shared with him that, you know, as a couple it almost might be interesting if you were to start dating again first and get to know each other slowly before you move in together. So I felt that for his well-being and for the couple to have a chance to get to know one another and rebuild a relationship, it would have been better for them to have a bit more space.

Q. Did he seem to understand this concept of perhaps they need more space?

A. I think he understood it, but he'd already ... he already seemed to have his mind made up and he mentioned things like, Well, it wouldn't make sense for me to pay for an apartment if she's got ... she's living in the house, it would be a waste of money. So, you know, he would sort of put obstacles in there as reasons why he didn't want to do that and I can't ... I just can't say why exactly he was resistant other than maybe he just

made up his mind that this is the right thing to do, that a husband and wife should live together and so he wasn't open to other possibilities.

Q. You talked back at the start about his sort of thought process where he said he'd like to be a good father and a good husband and then he had difficulty really defining and understanding how he could achieve those goals. Is that ... are you seeing some of that similar thought process when he's responding and saying, Well, it's just a waste of money, that's why I should be living with my wife?

A. Yeah, it spoke to maybe some difficulties with decision-making, with consider- ... like, considering all the different things to be considered, factors, when you're making a decision.

Q. It's during this meeting as well, and around this timeframe, you start to talk about cognitive ... or what you see as perhaps some cognitive limitations with Lionel Desmond coming into the mix. I wonder if you can explain to us what it is you're seeing and ...

A. Well, this ... at this point it was very speculative on my part, and we were ... as a team we had all sort of identified that there seems to be something underlying that was interfering

with his ability to progress, to gain benefits from the program. Dr. Gagnon had explored personality traits. Dr. Ouellette had his diagnosis of mixed personality traits. Then we look at ... his wife added the information about language and mixing up words, and I don't know if it was this one or another one but that he had what he described as a concussion, had brain injuries.

So there were a lot of different issues that were unclear that hadn't been ... we didn't have the ... we weren't able to explore in-depth. So the cognitive aspect was just one more of those things, like is ... this is another thing to be explored. Is there a cognitive limitation, something that's blocking him from his ability to organize his thoughts or process information, to have more flexibility? Et cetera.

Q. So is it at this point that you're totally not sure ... you're not completely sure what's accounting for this but there's ... you're not ruling out the possibility that there may be some form of trauma ... brain trauma.

A. Yes, and I ... other than to say that it's something we wanted to have explored. I don't have any experience in brain trauma. So I could only say what I said, that there might be something else interfering here.

Q. And I understand at this page 260 in the last paragraph you say: "Mr. Desmond informed the writer for the first time that he had head trauma when in an accident with a military vehicle in Gagetown, New Brunswick."

A. Mm-hmm.

Q. So you ...

A. Yes.

Q. You understood that the vehicle accident was in New Brunswick.

A. Yes.

Q. Did he elaborate further on how that unfolded, whether he had treatment for that?

A. He ... yeah, he described the incident and said he lost consciousness and he said that he was seen by medical personnel and was told that he was fine.

Q. If I could have just one moment.

Page 262. We're now into August 2nd and there's a piece, anger management session, and I believe there's a video that's played, **You're Not In The Forces Now**. What's the purpose? What are you trying to accomplish at this group session and what's the significance of the video?

A. The video **You're Not In The Forces Now** is an excellent

video that is actually a Vietnam vet who became a psychologist and he demonstrates and explains some of the interaction between military training and PTSD symptoms. And he does it in a way ... because he went through the military ... and the training hasn't changed much since Vietnam and now. It's very, very ... he sort of writes it in an excellent way and demonstrates how the experiences of anger management difficulties, the hypervigilance, many of the things they experience as symptoms were actually things that they ... that were trained into them as soldiers. For example, hypervigilance. Well, they were trained to react instantly to any kind of command through repetition, repetition, repetition.

(14:00)

So the way that it's explained often many of the people that I play it for are ... they respond very well to it, shall we say. It speaks to them and they can see how clearly some of the things they're experiencing now are part of how they interact with the training that they had and the military culture that they learned.

Q. And did you get any sense of how Lionel Desmond was comprehending that information?

A. I don't recall anything. If there had been an

unexpected response I would have noted it in the note. So that there's not comment on how he responded says to me that he watched it in his room and there was nothing in particular to note about his reaction.

Q. If we could turn to page 263 and 264, this is a progress note that you made from August 12th, so we're now a few days before Lionel Desmond is ultimately leaving Ste. Anne's. I understand that you receive a telephone call from Shanna Desmond?

A. Yes.

Q. And what was the purpose of Shanna Desmond reaching out to you three days or so before Lionel Desmond's leaving Ste. Anne's?

A. She wanted to get an idea from me of what his progress was.

Q. Were you able to have that discussion with her on the day she called?

A. No. I told her at the time I thought it best for us to have that conversation with Lionel Desmond; that this is something we would normally do anyway. And it's important if she has concerns about his return that it be upfront before he leaves and that we can share those things, and I would be there just to facilitate the conversation.

Q. And as a result of ... do you recall ... your progress note says August 12th, so that wasn't necessarily the day she phoned. Am I right on that? Or would it have been that day?

A. It could have been that day. Normally, if it's ... normally, if I'm writing it on a day that's not the day I met the person or spoke to the person I would have the date at the top of the note, so it probably was the day that I signed it.

Q. So as a result of that telephone call from her where she's requesting an update on the status before Lionel returns home you, in turn, I guess reach out to Lionel Desmond about that. And what sort of discussion takes place between you and Lionel and how is he taking the news of that potential call?

A. I did speak with him soon afterwards and mentioned that there was ... that she had called. He accepted to have the conversation. I seem to recall him seeming a little bit down during that conversation. He was getting closer to his discharge. He was feeling more anxious and worried about what was coming.

Q. Did he seem to want to have that phone call with his wife before he went home?

A. He didn't express wanting to nor did he express not wanting to. He seemed somewhat neutral.

Q. Did you get some sense of there was a bit of anxiety or apprehension surrounding Lionel Desmond and having that phone conversation with his wife?

A. Not particularly, other than I do note here that, yeah, that he appeared tired and somewhat discouraged.

Q. So ... and I understand that you might have attempted to call her on this day but you were unable to?

A. Yeah. There was a mixup with the time change, his wife thought we were calling at a certain time but it was Montreal time.

Q. And during this session with Lionel Desmond, again there's the continued discussion about the conflict with the nurse I believe?

A. Yeah, at the very beginning of the meeting he mentions it, yeah.

Q. What is he still hung up on as it relates to the nurse?

A. He was upset this time because he had spoken with the general practitioner about it and the doctor had supported the nurse, saying that the nurse had done the right thing, which he was irritated by. That she seemed to be taking the nurse's side.

Q. Earlier you mentioned that there were examples where Lionel Desmond could sort of let conflict go or walk away from

it. Did this appear to be the opposite of that, he just continued to revisit?

A. Well, actually no. In this case he did talk about it but it didn't take up the whole meeting. We reviewed it at the beginning, we discussed it and then he did let it go and we moved on to discuss the reasons that I had come to talk about, his conversation with his wife and so on. So I actually at that time would have seen that as a positive sign that he brought it up and he expressed how he felt about it, he was irritated but then he let it go and he was able to continue and stay with us for the rest of the meeting without going back to it at any point.

Q. In terms of sort of responsibility for the encounter, did he still remain of the position that it was all the nurse's fault and nothing to do with him?

A. I don't recall him ever at any point acknowledging or saying anything about his own responsibility in that conflict.

Q. You note at page 264 again this ... it's brought up about the accident with the military tank and he indicates that he might have had an MRI done.

A. He said he remembered having an MRI but that he hadn't gotten the results.

Q. And did you have access or did you know of any medical

document that was an MRI as it related to this disclosed accident?

A. No. No, not that I was aware of.

Q. He ended up bringing up consuming malaria pills while in the military. What did he mention about that?

A. He said it was terrible, actually. He said it was an awful experience. He gave me some examples and I can't remember what they were, but it sounded like he was having some more paranoia, some ... a lot of increased anxiety. Just that there were awful, awful side effects of this medication. He did not want to take them.

Q. But at the same time this is him disclosing it to you but you didn't have access to sort of any Canadian Armed Forces' records that would have said what type of medication it was or ...

A. No. No. I wouldn't have. I mean, it's ... He's not the first or the last veteran that has spoken to me about malaria pills and how the ones that they took had terrible side effects but I don't have access to that information or specifically what it was.

Q. And there was some discussion about his views on the group Marijuana for Trauma. How was his interaction ... how did

he describe that interaction to you?

A. He was on a bit of a tangent I believe at this point, but he talked about it ... I get the impression that he was ... he felt some pressure to use marijuana. About getting sucked in to using marijuana again. It was something that I guess somebody was promoting and saying it's going to make your pain better. Someone was promoting it and he was feeling a certain amount of pressure that he should use it.

Q. Did he express to you whether he found cannabis consumption helpful in any way?

A. He did at one point say that a topical form did help with his pain.

Q. The what form? Sorry.

A. Topical. There's an oil that you can put on that he would use ... he had used in the past and he said that helps to reduce pain.

Q. Did he ever discuss with you the effects of consuming it through smoking it?

A. No, he did not. He told me ... I'm pretty sure he told me that he had never smoked it or he did not want to smoke it.

Q. Okay. So ... Are you sure on that point or ... I just want to give you an opportunity?

A. No, I'm not sure on that point. I seem to recall him saying that he wanted me to be very careful about what he took into his body. I don't know ... but that's specific to marijuana, no, I'm not sure.

(14:10)

Q. So if we turn to page 263. I apologize, page 265. Sorry. We're still at August 12th, so a couple of days before he is leaving. There's some discussion about him getting to the airport and you're having a conversation with him. What was the difficulty?

A. Mr. Desmond had been under the impression that he would be accompanied to the airport by someone in the program, possibly because when they ... when a person arrives in Montreal one of our nursing staff meets them at the airport to accompany them to the hospital. And when he discovered that that's not actually ... generally speaking, by the time a person is ready to leave we don't offer accompaniment, they're usually okay to go on their own. So he was quite angry that this was something he thought had been promised to him and that now he was being told that it wasn't standard.

Q. And in terms as a result of it, did he say what was going to happen if somebody didn't drive him to the airport or

what he was going to do about it?

A. I don't recall him saying he was going to do anything about it particularly, just that he didn't think he should have to pay for a taxi and he didn't want ... feel he should have to keep the receipt if he did pay.

Q. So if I understand that: So if he did have to pay he said I'm not going to keep a receipt and submit it for reimbursement?

A. Yeah. Yes.

Q. That to me, on an everyday level, seems like the only person it's harming is him really.

A. Yeah.

Q. Did he seem to grasp that concept? He's making this declaration that, you know what, I won't submit my receipt for reimbursement if I have to pay. Did he seem to grasp that the only person he's really harming is himself?

A. I don't think at that point. No, I don't think he really made that connection. I think in his mind he was grasping at ways to feel like he had control over the situation and, Fine, if you can make me pay but I'm not going to keep that receipt. It was a bit of clinging to something he felt he could control.

Q. Do you recall him on another occasion saying something

about as a consequence, Well, I won't take my medication? Do you recall that?

A. I don't recall that, no.

Q. Okay. So in terms of a control ... taking back a control aspect, you talked about a number of things. You talked about the airport, I'm not going to submit a receipt so I'm taking back sort of the control. I'm going to leave the program, I'm taking back control. And you talked about this aspect of control in terms of I'll make comments of suicide, and then she comes ... Shanna Desmond finds him with the gun, cleaning his gun ...

A. Mm-hmm.

Q. ... and you talked about that in a control context.

I wonder if you could elaborate further. What do you mean by it's his way of taking control?

A. Well, I think it's ... there's a lot of different factors. With control, it can be when someone is feeling particularly vulnerable they need to find ways to feel like they're the ones in control. And I mentioned earlier anger ... expression of anger often is a way of regaining control, feeling an uncomfortable emotion, you'll become angry rather than experience the uncomfortableness and the anger makes you feel

like you're more in control.

So certainly when somebody is feeling vulnerable, they will find ways to feel or they may try to find ways to feel like they have more control over their situation.

Also the ongoing theme that we've brought up of him having this underlying fear of abandonment. Abandonment is a situation where you feel helpless, that some ... you've been left on your own. So that also would spur, I think, the need to find situations, to find a control in situations where he's feeling a fear of abandonment.

Q. Overall at this point, how do you think he is coping with the idea that he's returning back to his community? He's returning back to that civilian lifestyle. How is he coping with that, would you say?

A. Very honestly, I think he was feeling quite overwhelmed by the idea of returning home. He had his ideas. I mean, we had a good conversation at one point. He had some more solid plans about how he was going to build a relationship with his daughter. There were things that he was looking forward to, being able to be in the country, do his cycling, do his outdoor time.

But so for ... in a general sense, I think he was feeling positive towards what was coming, but when you got into the

details of planning it and, you know, what if that doesn't work could he pull something else in those details he would become more overwhelmed and just ,had a difficult time managing that.

Q. Did you think that he was sort of capable of considering different alternative plans, much like well, my relationship with my wife clearly isn't as good right now so maybe it's not going to be as easy as me moving back in the house with her and get an apartment? Was he able to sort of do that analysis?

A. Not a great deal, no. He ... I think at one point he showed some open ... I tried a few times in different ways to discuss those different options with him. At one point after a conversation with his wife on the telephone he did seem to show, Okay, well, maybe I could consider that, but no, he wasn't terribly open to other possibilities.

Q. From your standpoint, and I understand that mental health is sort of ongoing, it can fluctuate, and wellness is something that's always ... you build upon it.

A. Mm-hmm.

Q. How was he ever going to get there in terms of his ability to understand if option A doesn't work maybe I should shift to option B because if I keep pursuing option A it's going

to cause more chaos and turmoil for me? What do you think he needed to get there?

A. Yeah, that's a really big question. That's something I can answer that in many ways. But from our perspective of when he left what we really thought was primary important in order for him to be able to get to those places that he needed to go, was these explorations of personality traits, of anything that might be underlying that might be blocking him from being able to make those leaps. To have a little bit more flexibility in his thoughts. To be able to think plan A, plan B and react and control his reactions when things didn't go the way he wanted them to.

So, yeah, there's many different strategies to go from ... to get to where he wanted to go, but in his case we felt there was a lot of exploration needed to figure out specifically what were the things that were blocking him from being able to use those strategies.

Q. Was he ever going to be able, in your opinion, to do that on his own, independent of help?

A. I don't ... at the time no, I would have thought he really needed some support to help him to figure out what those issues were.

Q. We now know that there was approximately really, I guess, a four-month gap in he leaves Ste. Anne's and about a four-month period before he really has any assistance in terms of a mental health or a healthcare provider of any sort or even sort of case manager to help him with his day-to-day affairs.

You see him so close to leaving Ste. Anne's. How critical is it that he have some sort of interventions in that early phase, in the early weeks and maybe month that he leaves?

A. I definitely think, you know, for everybody it's important to have a smooth continuity of care without a gap, and for him because of the level of change he was engaging in, yeah, it would have been very important to have people to support him through that change.

Q. Is it possible sort of in your view that with all of that change and all of those stressors that would be attached on top of the underlying psychological diagnosis, that his condition maybe could have gotten even worse in that period of time?

A. Yes, I think that's possible. It's not ... I'm trying to ...

Q. I guess ...

A. ... to go from the services (inaudible - audio) ...

Q. I guess rather than say was it possible, was there a

risk to that happening without interventions?

A. It certainly is not something we would ever recommend, to have someone leave our program and not have any follow-up for a length of time such as this. I do know that the team in New Brunswick was working very hard to try to transfer as quickly as possible. His move made it difficult to apply all of the different ... the services. But yes, the going from a program where he was getting a lot of support to a situation that was completely new with a lot of stressors and without any support would have been extremely difficult.

Q. And I think you indicated earlier that the expectation would have been that Lionel Desmond would expect his return to the community and accessing all of those various resources would have been a part-time ... equivalent of being a part-time job, I believe.

(14:20)

A. Yeah, yeah, you could say that.

Q. So I'm going to ask you about the phone call to Shanna Desmond, August 12th is your note on page 266 and 267. So ultimately you were able to facilitate a phone call between Lionel Desmond and Shanna Desmond. Who else was present for this phone call?

A. (Inaudible) Julie Beauchesne.

Q. And so all three of you would have been able to observe and listen to the entirety of the conversation?

A. Yes.

Q. So just before the phone conversation happens, I understand in the second paragraph you noted that there was some sort of lead-up discussion with Lionel Desmond before the phone call is made. Why does that discussion take place and what are you trying to accomplish there?

A. We always do this when there's going to be a conversation with a third party, is to make sure that the person who is our client that their confidentiality is respected. So if there are things that he does not want us to discuss that we don't discuss them, and if there's things ... if he has specific expectations that he wants to discuss, that we make sure that we include those in the conversation.

Q. So were there any things that were identified that Lionel Desmond would have to sort of prepare himself for before this call took place?

A. No, he just said ... yeah, he just said he was willing to listen to what she had to say.

Q. You indicated that you said on the fourth line down:

"Mr. Desmond seemed slightly more animated than he had been the first time this was discussed."

What do you mean by him being more animated just before this phone call?

A. Well, in the previous note where I had mentioned that I had noticed that he had his head in his hand, eyes closed and he seemed quite discouraged. Whereas in this note he was ... in this meeting he was more ... he was not looking discouraged. He was not looking sort of passive about it, he was looking like he was ready to have this conversation.

Q. And I understand that you opened the conversation ... When the phone call is made you initially open it up to Shanna Desmond to lead off the conversation?

A. Yes.

Q. And what do you recall? What does she bring up? How does this start?

A. She basically names her concerns. That she feels that he's not as ... he's still having a lot of anger towards her. She mentioned this nightmare that he used to have when he's violent with her. So ... and she just talks about that being a concern. That are you really ready to come home and be with us given that you seem to be more angry and more paranoid about my

fidelity.

Q. So she brings up, initiates the concern she has. Basically, to rephrase it, she said she's worried about his increased anger towards her?

A. Yes.

Q. And does she specifically say that there is an increase in anger towards her?

A. She says that ... yes, that his paranoia and anger towards her have increased.

Q. Did you get a sense of when they increased?

A. No, she just ... my sense was that it had ... was gradual in the last week or so before his discharge from our program he had become more ...

Q. Had she ...

A. ... agitated.

Q. And she specifically makes mention of the dream and it's in quotes. So is this something she said, "cuts her into a million pieces"?

A. Yes, she mentioned that nightmare.

Q. And then what was his reaction to her bringing up, you know, your increased anger, your increased paranoia and the dream? What was his reacion to that?

A. It was two separate reactions for the anger and the paranoia, these didn't deny. The dream he was upset, he was frustrated, he said it's been a really long time since I've had that dream and I haven't had it ... he didn't feel it was pertinent to today's conversation because he said he thought it was in the past.

Q. So did you take from the conversation that she was concerned that he had increased paranoia and anger directed at her?

A. Mm-hmm. Yes.

Q. Did she say what she was concerned about?

A. I think most of it was the ... just the accusations. That he would accuse her of maybe cheating on him or taking his money or ... becoming easily angered by things that she'd said.

Q. Did she seem to say ... did you get the sense that she didn't want him back in the household as long as that was present?

A. She didn't say that outright but she did say that she wanted to see improvements in this area.

Q. And you indicated that ... I guess four paragraphs down, you say: "Through the course of the conversation, both Mr. Desmond and his wife expressed a great deal of frustration and

anger." Are their ... their voices, are they elevated at any point during this phone call?

A. Yes, they were both ... had raised voices and sometimes speaking at the same time.

Q. Did it appear as though they were really getting along on this phone call to you or the opposite?

A. No, at this point ... this part of the conversation definitely not, they were arguing, they were shouting; however, from my perspective, they were speaking to each other. They were telling each other things that needed to be said, maybe not in the best way but she was expressing to him that she needed him to trust her and he was expressing to her that he was hurt that she had left him in New Brunswick. And I don't know that he'd ever said that out loud to her, that it hurt me when you left and moved to Nova Scotia.

So although there was yelling, you know, it's not the ideal way to communicate obviously, but they were able to say things to one another that they hadn't said before to my knowledge. To me, at the time, I thought it was a step in the right direction ...

Q. So did it ...

A. ... particularly towards ...

Q. Go ahead, sorry.

A. Sorry.

Q. Go ahead.

A. Particularly towards the end, that they were both able to apologize. That she was able to acknowledge that it must have been hard for you when I left and he was able to acknowledge yeah, but I understand why you did. So, for me, it seemed like it had been a really good step for them.

Q. How long into the conversation did it take before they both started revisiting problems they had with each other or perceived problems they had with each other?

A. I think it started relatively quickly. Basically, once Mrs. Desmond outlined her concerns about some of his behaviour toward her he became discouraged and then he brought up the ... his feelings of hurt and anger that he'd been living alone in New Brunswick. So it was relatively quickly in the discussion that those things came up.

Q. So overall how would you say their communication style with each other was during this phone call?

A. I would not have said it was ideal or even particularly healthy. However, like I said, I think sometimes just getting it out there however it gets out there. Sometimes it's messy but getting those feelings out there is important and then you can

try later to find a better way to get it out. But they were able to say the things that they wanted to say and that to me was a positive thing.

Q. You indicate that you said: "In Mr. Desmond's case, this entailed shouting and swearing and repeating himself."

A. Mm-hmm.

Q. Do you recall what he was saying in terms of swearing?

A. No, I don't recall specifics ... specific words, swear words.

Q. I'm trying to put context to your written word but when you say "shouting", to me that sounds very different than raised voice.

A. Well, it would have been a combination. I think an acceleration or an increase from starting with the shouting ... or starting with, rather, a raised voice and that escalating to shouting and swearing possibly, and then decreasing to ... as he calms down decreasing until he was able at the end to speak more calmly.

Q. So would you say that even though they ... it was maybe good that they started to share what they really believed about each other, was it unhealthy the way they shared it?

A. The yelling certainly is not the healthiest form of

communication, that's fair.

(14:30)

Q. And to you ... and I recognize that you don't know the entirety of their relationship, but you're invited into the conversation of two people. To you, did it seem like this is a pretty rock-solid steady relationship or what were your thoughts?

A. No. No. It was a confirmation of what we had already observed, that, no, this is not a relationship that had a great ... they weren't doing super well. They hadn't been living together for a long time and there were a lot of questions on both sides of feelings of hurt and frustration from both of them.

So, like it's mentioned in there, I had suggested, at some point, they might consider couple's therapy to help them figure out what they want and how they can rebuild their relationship. I don't know that ... I don't think that couple's therapy would've been recommended right away because he had a lot of other things to work on, but, no, it was a relationship that would have needed a lot of support to try to make things work.

Q. What was Shanna Desmond's main concern as relayed through that phone conversation?

A. I think it was the ... there was the two things, that the increased anger and paranoia were really bothering her.

Q. Does she take it a step further? And I'm looking at the third paragraph from the bottom. You noted: "Mrs. Desmond's main concerns were that she feels he remains too volatile and angry. She wants reassurance that he is able to regulate his moods. Unfortunately, Mr. Desmond's behaviour during the phone call clearly demonstrated to her that he continues to struggle with this." So is that an accurate reflection of your interpretation of her concerns and the phone call itself?

A. Yes.

Q. So, in her opinion, did she ever describe to you what she meant by "he's too volatile"?

A. I think by "volatile", she meant what she had discussed earlier, that he was unpredictable, that she didn't know what would set him off.

Q. And too angry.

A. In the same vein, that the anger was easily triggered and she was never sure when it would be triggered.

Q. And when you said she wanted some reassurance, was it ever flushed out as what was the concern? Why did she want the reassurance?

A. She simply didn't want to have to walk on eggshells all the time. She wanted to know that he was going to be able to get

to a point where he could control his ... he had more emotional regulation and it wouldn't have to be so awkward not ... just trying not to set him off.

Q. And during this conversation, was there ever any discussion about their daughter, Aaliyah.

A. Not in this one, no, we didn't discuss their daughter.

Q. If you look at the bottom of page 266, the second-last paragraph from the bottom, just see if you can refresh your memory from there.

A. Okay, yes.

Q. And so what was Aaliyah ... how was she brought into this conversation?

A. Well, that was why I don't remember it really is that it was just a one ... when he was able to acknowledge at the end that he understood why she had left, he just said it was the right decision for their daughter, that she go and live with her parents, but she'd have support from her parents to help raise the ... to help take care of her daughter.

Q. So I get the sense that he agreed that maybe it was the right decision for her to take his daughter?

A. Yes, in the context that I believe, at this time, he was still active, so he was going on missions.

Q. Okay.

A. So ...

Q. And I understand, on 267, so how did this ... approximately how long was this phone call? Do you remember?

A. I do. Could've been about 45 minutes to an hour, approximately.

Q. And from Shanna Desmond's perspective, how did the phone conversation end?

A. She ... I mean we thought either she got cut off or she hung up the phone.

Q. And you put in sort of brackets here on page 267, "Suspect she had become too emotional to continue."

A. Yeah. That was my feeling at the time that, you know, they'd spoken to each other, there had been an escalation where they were both sort of shouting, and then a de-escalation where they were both able to acknowledge each other's points, and then after that, she ... I think she just ... it was too much. She just needed to end it.

Q. So when the phone call ends - it's a hung-up call - how is Mr. Desmond at that point?

A. He was very ... he was sad. He was ... he seemed very tired, drained, and he was very sad.

Q. And what are his thoughts now on his plan that he's going to move home and live with his wife and daughter?

A. He did seem to show more openness to the idea of trying ... living separately for a while first, but I think his primary emotion at that time was sadness, that his wife wasn't waiting with open arms.

Q. Did you see him express any insight as to whether or not plan A of moving back in with his wife and daughter was maybe the best?

A. He did not at this time, no.

Q. Do you know if the content of that phone call and his plan of where he was going to go was ever conveyed to maybe his case manager at Veterans Affairs or anyone?

A. It was something he and I discussed at some point. I asked him earlier if he had shared this with his team and, yeah, he said that they were aware and they were coordinating the transfer.

Q. I know that the interdisciplinary conference took place before this call but, clearly, at this point, somewhat questionable as to where in the world Lionel Desmond is going to go when he leaves Ste. Anne's. Is that fair to say?

A. At this ... in this conversation here? Yeah, it had

become up in the air a little bit. He had gone from being certain that he was going to live with his spouse and her parents to now, at this point, Well, I'm not sure because maybe she doesn't want me there.

Q. And did you have any other conversations with Shanna Desmond after this date?

A. I don't believe so after this one. I don't think so, no.

Q. So when Lionel Desmond left three days later, where did you sort of ... did you have any idea where he was going? I know he's an adult and can ...

A. Yeah, my understanding was that he was ... he had planned to follow through on his plans and go ... he was planning to get the rest of his belongings and go to Nova Scotia right away and either ... as far as I knew, he was going to keep on going with his plan to move in with Shanna.

Q. And I believe we know that his Veterans Affairs case manager, I'm not sure if she might've accompanied him to the airport or made, at minimum, made arrangements for that to take place. Do you know ... like is it fair to say that the relationship between Lionel Desmond and his wife, Shanna Desmond, as you saw it, was pretty volatile.

A. Mm-hmm. That would be fair to say, yes.

Q. The volatility of this relationship, was it ever conveyed to anyone from what Ste. Anne's observed?

A. It would've been conveyed in, possibly in our communications. I would imagine that we would've conveyed it verbally in our final discharge summary, the teleconference. Not necessarily the volatility, but her concerns. We would've conveyed that, you know, he still has a long of anger management difficulties which makes it difficult for the spouse and the child and she's concerned about his ability to regulate his emotions. I don't know that, specifically, it's not ... probably would not have gone into specifics of this conversation.

Q. So I know the interdisciplinary discharge report, it's there with the recommendations. It doesn't mention anything about the volatility of the relationship. Do you know if there was ever any other ...

A. No, it's not in the ...

Q. Sorry, go ahead.

A. No, it's not in the written report, but it would be something that I would've included verbally when I spoke to them over the phone.

Q. Do you know who you would've said ... who you would've

told that verbally to?

A. It would've been in the context of the final teleconference.

(14:40)

Q. The one that happened before this call.

A. No, it wasn't before ... was it before this one?

Q. This phone call happens on August 12th with Shanna Desmond.

A. Oh yes. So, as I said, the details of this conversation wouldn't have been included, but the overall context of the relationship being one that's not an easy one, that's requiring support, all of that would've been included.

Q. And ...

A. And prior to this, we knew that it was volatile, but that he was volatile, and that the relationship was struggling.

Q. And, okay, so that would've been communicated verbally, I take it.

A. Yes.

Q. And to whom and when?

A. It would've been during that teleconference.

Q. Okay. So you're saying it would've been conveyed to his case manager from Veterans Affairs at that conference?

A. Whomever was present. You know, it is possible that it was not, that it was something that didn't get included but, generally speaking, in my portion, I don't always write everything down but, in my portion, I will talk about the family dynamics and will express that the spouse has expressed some concerns. And, also, I remember feeling it was important to let them know that she felt she wanted to be included as much as possible in the communication with them so that she could share her point of view.

Q. So, yeah, I was going to get to that because she felt very strongly that she could be of some help and it was important to convey what she had to offer into what was happening.

A. Yes.

Q. Is there any sort of benefit in ... and we're looking back, but is there any sort of benefit including ... we have an interdisciplinary discharge report, but when it involves that transition to the community and that pressing, Home life is terrible, that there maybe be an appendix to that sort of discharge report that might outline and say, Look, there's some marital issues here that could be looked into, and contact with the spouse, try to pursue that, if possible?

A. Yeah, I think that would ... there's merit in that and

we will ... we'll often do that in the form of having a section where we suggest that the couple receive therapy. And certainly, knowing, you know, what happened since, then absolutely. A little bit more focus and more information on, and everything that we observed in the couple could've been included but, again, it's hard to separate what we know now from what we knew then, so what really was the most glaring thing for us at the time was this need for exploration, and the other stuff was all communicated, but the focus was we need to figure out why he's not responding to this treatment.

Q. And I think it's fair to say that you were only dealing with Mr. Desmond as a snapshot of a period of time. That was something that was going to have to continue after he left Ste. Anne's.

A. Yes.

Q. And ...

A. Yeah, we were seeing it ... go ahead.

Q. And, in fairness to you, at the time, you don't have the benefit of all of these questions being put to you, I guess. Is that fair?

A. Yeah, that's fair, thank you. Yeah, it ... you know, it's ... I'll tell you that when this happened, when we found out

what happened, I went through every single note that I had done looking for something that I had missed. And if I take away the knowledge that I have of what happened when I go through this, everything that's in here is stuff that we hear from all or most of our clients discuss that they have, they have fights with their spouses and they yell and they have trouble managing their reactions and everyone in the family is walking on egg- ... everything that's in there is stuff that we hear from 90 percent of our clients. So none of it jumps out, necessarily, as shocking or red flags. It's just, okay, so this is typical of this profile.

Q. And that's why I want ...

A. And it's not to downplay ...

Q. And I think that's ... in fairness, that's why I want to ask this, to be fair to you, is what you saw here with Lionel Desmond, from what you see on a regular basis at Ste. Anne's, is it abnormal or unusual?

A. Really not. None of the things that we saw were unusual in the context of all the other sick people we see. He was ... I would say that he was maybe a little bit more rigid than the average. They all tend to be rigid, but he was maybe a little more extreme in that area but, other than that, he didn't

stand out as particularly more than others.

Q. I don't have any further questions, Ms. Hamilton. I know I've maybe asked you a few hard questions, hopefully, but thank you so much for helping Judge Zimmer on his Inquiry.

Your Honour, I don't have any further questions for the witness.

THE COURT: Thank you. We have counsel in the room who may have some questions for you, Ms. Hamilton, so I think we're going to poll them to see who has questions at the moment. Mr. Anderson?

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

THE COURT: Thank you. Ms. Ward?

MS. WARD: We will have some questions, yes.

THE COURT: All right, you're going to defer. Thank you. Mr. Macdonald?

MR. MACDONALD: No questions, Your Honour.

THE COURT: Thank you. Ms. Miller?

MS. MILLER: I have some questions, Your Honour.

THE COURT: Yes, please. Come forward. Ms. Miller?

MS. MILLER: Oh, I'm sorry.

THE COURT: No, I'm sorry. That was meant to be ...

MS. MILLER: I thought you were canvassing.

THE COURT: Sorry. That was meant to be an invitation to come forward.

MS. MILLER: Thank you, Your Honour.

CROSS-EXAMINATION BY MS. MILLER

(14:46)

MS. MILLER: Good afternoon, Ms. Hamilton.

A. Good afternoon.

Q. My name is Tara Miller. I am counsel representing the personal representative of Brenda Desmond. Brenda Desmond was Cpl. Desmond's mother. And I also share representation with respect to Cpl. Desmond's daughter, Aaliyah.

You started work at Ste. Anne's in April of 2016, is that correct?

A. Yes, I did, yes.

Q. And we know, of course, from the records that Cpl. Desmond would have first been admitted on May 30th, sort of within no more than two months of you having started work there?

A. Mmm.

Q. Correct?

A. Yes.

Q. Okay.

A. That's correct.

Q. And your case ... how many clients would you have seen between when you started there April and when Cpl. Desmond would have been admitted in the stabilization unit on May 30th?

A. Probably about ... in two months, between five and ten.

Q. And then through the period of his stabilization and his time in the residential treatment phase, how many clients would have been under your care as a social worker during that period of time, from May 30th to ...

A. At that time, there were ... pardon me?

Q. Sorry, from May 30th to when he would've been released on August the 15th.

A. So in a three-month period, we never had more than ten people on the unit and, at the time, there were two social workers, so I would have five at any given time. So, you know, people arrive at different times. I would say, in that period, it could've been anywhere from ten to 15 people that I'd have seen.

Q. So you would've seen about five to ten before Cpl. Desmond showed up and then ten to 15 ... would that have been in total? Ten to 15 before he had left, from the time you started in April?

A. Yeah. I would guess, yes, between ten and 15 from the time he arrived to the time he left, yes.

Q. Okay. Your last comments to my friend, Mr. Russell, that the presentation generally of Cpl. Desmond during the residential treatment phase was not unusual for most of the clients when they would've been there. Would that have been the case in terms of the five to ten clients you'd experienced before he arrived?

A. Yes. These are ... many of the things he struggled with are things that we see consistently across many of the people who come to our program.

Q. Okay. And so that was the case before he arrived, with your experience with clients, and after he has left, in your current tenure there at Ste. Anne's?

A. Yes.

Q. Okay. My friend took you through a report of yours where you recorded that Cpl. Desmond reported taking medication for malaria, or being prescribed medication for malaria, when he was in Afghanistan? And ...

A. Correct.

Q. ... as I recall your note, you indicated that he had complained of significant side effects?

(14:50)

A. Yes, he did.

Q. Do you have a recall as to what those side effects would've been, Ms. Hamilton?

A. Unfortunately, I don't recall specifically what he said. He did describe them as being terrible and he, in the context of it, he started to describe in detail some of the more violent, gory things that he had witnessed, but that those were easier to deal with than the side effects that he was experiencing with the medication.

Q. Okay. And did you have a sense of the duration of the side effects from this malaria medication for Cpl. Desmond?

A. No, I don't recall, unfortunately.

Q. Okay. And do you have any ... did he share with you the name of the medication that he was given?

A. I'm afraid he didn't, no.

Q. Okay. You did indicate ...

A. I don't know what it was called.

Q. You did indicate ... I didn't think you would be able to give us that but I thought I would ask and not assume. You did also indicate that it was not uncommon. There'd been a lot of veterans that have provided feedback to you in the course of

their admission to Ste. Anne's about significant side effects from malaria medication that they had taken while in Afghanistan?

A. There were a couple. I don't know if it was all in Afghanistan, but there were at least two or three people that I spoke with that mentioned having to take them and mentioned having ... the more recent one, he mentioned really severe nightmares that he experienced, and other people that he was on the mission with were experiencing, as a result of the ... that they felt was a result of the malaria medication they were taking.

Q. Okay. And those individuals that indicated the nightmares, do you recall if they had been on the Afghanistan mission or was this another mission they had been on?

A. I don't recall which mission he was describing at the time.

Q. Okay. And, again, with those individuals and the side effects they were experiencing, do you have a sense of the duration of those side effects? So, for example, the nightmares. Were those nightmares continuing to happen while they were at Ste. Anne's?

A. If I recall correct, no, not ... the nightmares that happened at Ste. Anne's were nightmares related to PTSD, I

believe, not related to the malaria medication. When ... the most recent conversation, which is more fresh in my mind, of a veteran who spoke to me about it, he said it would be the day that they took the medication, it would be that night that people would be having really severe nightmares.

Q. Okay. So it would be contemporaneous with the prescription of the medication. Okay, thank you.

A. Yes.

Q. I want to move now, Ms. Hamilton, into just a discussion around the impact of PTSD and the issues that you had ... members before you, on their families. You know, you ... a couple of things you said. Very common for spouses of PTSD clients to be walking on eggshells, uncertain of what will trigger their spouse into a rage. And you said anger management was a very, very typical thing for veterans with PTSD. Is it fair to say that, typically, that the families would bear the brunt of that because they would be the individuals closest to these members?

A. Yes, I think that's fair to say. It's often very hard on the families.

Q. And, certainly, that seems to have been, and I'll let you agree with me, but that seems to have been the sense from the

information you got from Shanna, that detailed note you had taken based on your conversation with her at the end of June. She was describing some disruption, significant disruption, in the family. And certainly an impact on Aaliyah. She was afraid to leave Aaliyah alone because of the impact of it on Aaliyah's own mental health. Is that a fair characterization?

A. Yes.

Q. In your ... you talked about the training you have in systems-based family intervention.

A. Yes.

Q. And I want to just explore that a little bit more. You said sometimes the family situation can be quite healthy, and so it may not be as big a focus, but, certainly, it sounds like, for the majority of the members that you're treating who have these anger issues impacting their family members, that it is actually a very real piece of what you need to deal with in terms of your social work, clinical work, at Ste. Anne's. Is that fair to say?

A. Yes. I would add that people are different stages. So there might be some people who will talk about that eggshell thing, of the family members walking on eggshells, but they'll talk about it as something that occurred in the past when they were, you know, at the beginning of their recovery and that this

was something. So they will share that information in the context of anger management groups as a way of helping their peers who are still struggling with that. So not everybody that comes through the program is currently, at this time, having that situation at home. Some of them have already gone through it and things have improved.

Q. Okay, but is it ... would you ... certainly, for Cpl. Desmond, that was not the case. Things had not improved.

A. No.

Q. And is it ... there ...

A. Things had not improved and ... sorry.

Q. No, you go ahead.

A. They hadn't improved and they hadn't had much, from my understanding, they hadn't had much opportunity to improve because they hadn't been living together for some time.

Q. Okay. So in terms of the work you do with somebody like Cpl. Desmond at Ste. Anne's under this systems-based family intervention, are you working with the member or are you working with the family?

A. In an ideal world, if you're doing a systems-based approach, you'll be working with the family. In our context of our clinic, we can't really ... other than having these phone

calls that were described, we don't have many, many opportunities to include the family into the intervention, so we'll work with the individual. However, we try to include some of the ... many of the, concepts of the system, the fact the individual is a part of a system, and keeping that in mind and getting as much information as we can about what system they're returning to and how they can fit into it.

Q. Okay, but in an optimal ... and correct me if I'm misstating this, but in an optimal world, under the systems-based family intervention, would you be integrating the member and the family for optimal results?

A. If someone was conducting really, yeah, traditional, and I think the most effective systems-based family interventions, yes, you would have ... their meetings would be with the whole family. And it's something, it's a concept I think is important to inform what I do because everything that they do when they go home has an impact on their family, but we're not placed to be able to have family interventions with them all present.

Q. Okay. And is that just a structural reason? I mean, sometimes families are in other provinces and the nature of the inpatient facility is it doesn't allow for families to be there.

That's a structural thing?

A. Exactly, yeah. People come from all over Canada, so it's not ... we can't regularly invite people to meet with us.

Q. Okay. And if you were able to integrate the two, the family and the member, what would that look like in terms of timing, duration?

A. I think it would be completely ... it would have to be a different context, to be honest, because in our program, the residential nature of it, the fact that there are so many different services that are all coming together to provide support for this one individual, it's really focussed on the individual, and I try to, in my work, I try to bring in the family, but the duration of their stay is mainly about identifying strategies for them to better cope with their illness and with their difficulties.

So to do ... to really do systems-based therapy, I think it would be more in the community with a social worker, or whatever other professional works in that way, so the family can come in once a week and really do a good set of sessions in that approach.

Q. Okay. So are you aware of places where systems-based family intervention work takes place with the integration of an

individual and their family?

A. There are ... not specific to veterans. There are social workers here in Quebec that offer that to families in the community. I don't know of any that are specific, offering service to veterans.

Q. Okay, thank you. So outside of the ability to do that, what I understand from evidence from yesterday from Dr. Gagnon - but she told us to ask you about this - is that there is one day at Ste. Anne's where family can come in, and there's some structure around that day in terms of ... well, I'm going to let you tell us about that day. First of all, when is that day?

A. That day is generally planned two weeks, approximately, before the person leaves. We invite the family, usually one or two family members, to come to the program, to Ste. Anne's. We have a full day where each professional takes 45 minutes to an hour to explain, to do psychoeducation, talk about ... for example, Dr. Gagnon would come and talk about what PTSD is and explain that to the family. The OT would talk about how PTSD impacts a person's functioning, occupational functioning. And then I would do the part with the family where I would talk about the impacts that PTSD will have on the family functioning. And that's where I would focus more on the concept of this family

dynamic and how it can be difficult to make room for the person when they're returning.

(15:00)

I would also, in that, focus on getting ... asking the family member to let me know what their concerns are. Is there anything ... mainly they'll ask me how can they help, you know, how can they help support their spouse. And we need to work out that. Sometimes, if there's conflict, then that will be a good space to start naming what those different areas are and try to figure out what they need in order to get support to get through that.

Q. So for Cpl. Desmond, did his family come for that family day?

A. No, he didn't ... they did not, and I don't recall ... he would've been offered. It's always a part of our program that we say on this date, we're going to have a family day. Would you like to come? So we did not have one with his family, so I'm assuming that there was something ... some reason why his wife was unable to make the trip.

Q. Okay. And that, I take it, is a practical barrier sometimes to participation. It's certainly easier if family members are in the immediate vicinity of Ste. Anne's, but if

family have to travel from other provinces, is that a ... it seems like a barrier to being able to access that family day.

A. Yeah, it can be. It is reimbursed by VAC if it's ... because it is part of our program, so VAC generally reimburses the cost, which makes it easier, but, you know, in Shanna's case, she had her daughter, she was working full-time, so I think there was reasons why she wasn't able to make the trip.

Q. Do you know who would've had that conversation with Cpl. Desmond and/or Shanna about this availability of this one day? I mean, I don't see it in the records, so I'm wondering if there's any way to confirm this would ever have been conveyed.

A. We wouldn't have ... it's not in our records, but it would've been ... I would've mentioned it, Julie Beauchesne would have mentioned it, but it's one of those conversations that you have sometimes in the course of an individual meeting, but sometimes just, oh, we, you know, see them right around group. Oh, could you stay for a second because we need to talk to you about this. Most people have a family day. So the conversations about the planning of it and the offering of it may not have been noted in the dossier.

Q. Okay, you, we understand, had opportunity to speak with Shanna three times by phone.

A. I did.

Q. Yeah.

A. Yeah.

Q. Would you have reviewed with her, in any of those calls, the opportunity, particularly given the concerns she was expressing about the discord and the disruption at home for her and her daughter, would you have had an opportunity to review with her the ability to come for this day?

A. I would've thought I would have and I'm surprised, actually, that ... because it's something that I'm quite sure I would've informed her of, but it's not in any of the notes that I had took of our conversations, so we were perhaps more focussed on her getting out some of her concerns but I can't recall any point when I might've told her about it.

Q. It strikes me that somebody who is expressing these concerns to you about the significant disruption and concerns about escalating paranoia and anger would be benefitting from that type of family day at Ste. Anne's. Correct?

A. Yes. Yes. Which is why I assume I, at some point, had said, Well, this is something we can discuss, if you can come for this family day but, unfortunately, I can't remember. I can't give you details on when it was said.

KAMA HAMILTON, Cross-Examination by Ms. Miller

Q. You touched on this with my friend a little bit earlier as well. So outside of the family day for members at Ste. Anne's, I think you said there were some other external supports for families. You said there was an OSSI peer support group for spouses?

A. Yeah, there is.

Q. Okay.

A. They have ... relatively recently, there's peer support workers through OSISS that are for spouses of veterans.

Q. Okay. Would that have been in place in 2016?

A. I think it existed at that time, yes.

Q. And is access to that peer support group in any way predicated on consent from the member?

A. I'm not sure. I don't think so but I'm not a hundred percent on that.

Q. Okay. So there's the OSSI peer support group for spouses and then I think you said that VAC will pay for psychological support for a spouse if it's deemed necessary? Can you give us ...

A. Yes.

Q. ... a little bit more detail around the type of support that VAC will pay for for spouses?

A. They have access to unlimited sessions with a psychologist. I believe they can have six to eight sessions with a psychologist, individual, and they can have access to a couples therapist.

Q. Okay. And when you say "if it's deemed necessary", who deems it necessary? The individual?

A. Basically, the individual, the person. If a spouse contacts the team and says, I need this support, then, generally speaking ... from my understanding, without working for VAC, my understanding is they generally ... it's approved.

Q. Okay. And we will be able to ask VAC representatives that, but I just wanted to get your understanding, from being a social worker and being focussed on family intervention, what you understand resources to be outside of the structure of Ste. Anne's. So it's the OSSI peer support that VAC will pay for some psychological support and couples counselling. Is there anything else, Ms. Hamilton, that you can think of that exists as support for family members when they're trying to help their loved ones readjust with the inevitable legacy of the battle and the PTSD?

A. There's nothing in particular that I can think of. I believe ... I was reading through some of the stuff about Wounded Warriors and I think some of those programs, they will encourage

people to bring members of their family to the program. For example, Mr. Desmond had planned to bring his daughter to the equine therapy program that he was going to do, and that she would be welcomed there. So I believe many of the organizations do try to find a way to include family.

Q. Okay, thank you.

I want to move now to a subject about collecting collateral information from family, and it seems like you were the key person at Ste. Anne's in terms of being in a position to collect information from, in this case, Shanna Desmond. Is that fair to say, that that would fall under your umbrella and your role in the Ste. Anne's program?

A. Yes.

Q. Okay. And my understanding is that your ability to contact Shanna Desmond and/or any other spouse is predicated on the member giving permission.

A. Yes.

Q. Okay. But you did have permission from Cpl. Desmond. He didn't ... he had no resistance to that and you were able to gather some, I think you said, pretty valuable, helpful information from Shanna to help inform treatment and the path forward?

A. Yes.

Q. Okay. And without that consent, you would never have been able to gather that information.

A. Unfortunately, no, I wouldn't have been able to call her.

Q. Yeah. And in a mental health world and diagnosis, my understanding is that that collateral information is pretty key to being able to help optimize treatment and care.

A. Yes, I would agree with that.

Q. So I'm trying to think of ways and situations where members will not allow the consent. And we did see that with Cpl. Desmond, when he was admitted in the final days to St. Martha's, he did not give permission to a treating psychiatrist to reach out to his wife to get any collateral information. So in terms of, you know, thinking about ways, as we move forward, and recommendations for the future, I have some thoughts and I wanted to explore them with you in terms of how we can capture that collateral information, preserve it, and make sure it's passed on to the next care team.

So, for example, do you think there would be value in having specific sections of summary discharge reports which deals with collateral family information?

A. I think that could be helpful, yes.

Q. Yes. We know that when Cpl. Desmond was treated at OSI New Brunswick, his treating psychiatrist at that time had some interactions with the family, but it doesn't appear that was passed on. And then I think specifically about the information that you received - it was pretty detailed - and if that had been captured into the discharge report, it strikes me as that would've been a helpful starting place for the next care team, whether he's going back to OSI New Brunswick or to OSI Nova Scotia, to have that repository. Do you see any issues with that?

A. Issues with it? No, I don't. I think the more information, the better, and having the input from the people who are living with him and sharing his space and who care about him, that can't, it certainly can't hurt, and it would most likely be helpful.

Q. Yeah. The other thought I had, which might be a little bit more problematic, is we know that veterans are not allowed to come to Ste. Anne's if they have ongoing addictions issues. They have to come free of alcohol and free of any other kinds of drugs. So we know that there are some thresholds to entry and I'm wondering what your thoughts are about, as part of the

admission, that there's a mandatory spouse interview that happens. So that collateral information can be collected right upfront and it informs, from day one, the stabilization program and then the residential phase program. Do you see value in that?

A. Yes, I do. I'm smiling because I think that could be very helpful to get that information. And, in fact, one of the things we've discussed is having the - well, we talked about the family day - having something similar at the beginning of the program as well as at the end of the program so that we could have a teleconference day with the family members, with the consent of the member, so that we can get their perspective on what their hopes are and what their concerns are.

(15:10)

Q. Okay. So my thought is that if you had a member who says, No, I'm not allowing you to speak to my spouse, that could be, on some extent, could be considered a barrier to coming to the program because that collateral information is so critical to inform the path forward given that these are the people who are going to be living closely with them. What are your thoughts on that?

A. That's a little bit trickier because a person can

choose not to have ... can make that choice for a variety of different reasons. It may not be for bad reasons. It may be because their spouse is very vulnerable or going through a difficult time, or there could be any number of reasons that someone applying to our program prefers us not to contact their spouse. I would have a harder time making it an exclusion criteria, but I would be very, very supportive of the idea of making it something that we strongly recommend and ask the treating team to work with the person to encourage them to allow this to happen.

Q. So as part of the intake. And we know that at Ste. Anne's, there was an intake interview done but that that ...

A. Yes.

Q. ... could be broadened to include an intake interview with family to collect that collateral information at the front end.

A. I think that could be an excellent idea. The only place where I balk a little bit is the idea of making it exclusion criteria.

Q. Yeah.

A. But, otherwise, having that as part of the process, I think, would be wonderful.

Q. I just want to be ... I'm going to move off of that and to the ultimate sort of disposition of the discharge report, Ms. Hamilton. Just to be clear, you knew that Cpl. Desmond was not going back to New Brunswick. That was clear by the time of the discharge teleconference on August the 9th, and, certainly, it's reflected in the August 17th prepared date report.

A. Mm-hmm.

Q. If I understand, you indicated that once you were ... at that point, you were the holder of the pen on that report. Now it is the ... it's an admitting nurse, but, at that point, it was you.

A. Yes.

Q. You understood that that report, when it was completed, along with a closing note from the family doctor, or the general doctor, I guess, who would've seen the client throughout, and then a closing note from the psychiatrist ...

A. Yes.

Q. ... those three things would have been transmitted back to the origining ... or, sorry, the referral entity, which, in this case, we know is OSI New Brunswick.

A. Yes.

Q. Okay. So I'm going to ask that we go to Exhibit 244.

And this, just to help orient you, Ms. Hamilton, this is not ... it includes this record from Ste. Anne's, but it is not your Ste. Anne's record. It is the OSI New Brunswick records.

A. Okay.

Q. And if we go to page 84, and if we ... it's in French, but my recall and understanding of this, Ms. Hamilton, is that this is the transmitting facts from Ste. Anne's to OSI New Brunswick.

A. Mm-hmm.

Q. The discharge report has been completed and it says "Bonjour". My read of that is that, Here's the discharge report and here's also the report from the general doctor.

A. Yes.

Q. There's no mention of the psychiatrist's closing report in it. Does that strike you as odd?

A. No ... yes. Normally, the psychiatrist's closing report would've been there as well.

Q. Okay. And then if we can go through the document. I think it's nine pages of what was faxed, but there is no closing note or any record from the psychiatrist.

A. I'm not sure how to respond to that other than in our (inaudible - audio) procedure, it normally would've been

included.

Q. Okay, thank you. And it would've been important to include that note because it was Dr. Ouellette who had identified the mixed personality traits as a diagnosis ...

A. Yes.

Q. ... upon admission. Thank you.

A. Yes.

Q. Last questions for you are around the August 12th chart note in Exhibit 254. This is the progress note that Mr. Russell reviewed with you just at the end of your evidence with him. And this is, of course, the record of the call with Shanna Desmond and Cpl. Desmond. If I understood your evidence, I think you said that Cpl. Desmond told you that he was going to pass on his plans for the future to ... or he had passed on his plans for the future to his case manager?

A. Yes.

Q. Okay. The final line on page 267 says: "Follow-up. Share above information with the external team and in the interdisciplinaire." Can you give us an understanding of what that means?

A. Well, the interdisciplinaire, that's our interdisciplinary team meetings, so it would've been ... a plan

would have been to share the information in that ... in our next meeting with the rest of the team. To share the information with the external team, that would've meant an intention to make sure that the external team got this information from this note.

Q. Okay. So we know that the conference call with the external team took place on August the 9th. And we ...

A. Mm-hmm.

Q. ... know from reviewing the August 17th discharge report, as it was prepared, there's no reference to any of this information in that report. So is it possible, Ms. Hamilton, that this information was never shared with anyone outside ...

A. It's possible ... sorry.

Q. Is it possible that this information ...

A. Sorry?

Q. Is it possible that this information recorded in your August 12th note that chronicled Shanna's increasing concerns with paranoia and anger towards her, that was never captured outside of Ste. Anne's?

A. Yes, it's possible. I think it ... I'm trying to ... this conversation took place ... and it confirms from the stuff that we had already observed with the family. So, certainly, there are details in this that may not have been shared but the

overarching message that this was a couple that was needing support, that his spouse found it difficult with the rapid mood changes and the anger management difficulties, that information would've been shared.

Q. And where would that have been shared?

A. It would've been shared either verbally in the teleconference ... in fact, that's the only place it would've been shared really was verbally through a telephone conversation or in the teleconference.

Q. Okay.

A. Unfortunately, it's not ... you know, it's difficult when it's not written down, but it is information that would've come up.

Q. Okay. And this sort of takes me back to one of the suggestions I had about preserving collateral information in documents to move forward. You know, if there was a section in that interdisciplinary discharge report that was ... postdated this, then that could've all been captured there.

A. Yeah, that's a good ... I think that's a good suggestion.

Q. All right. Thank you, Ms. Hamilton. I appreciate your time.

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

MR. RODGERS: Yes, thank you, Your Honour.

CROSS-EXAMINATION BY MR. RODGERS

(15:19)

Q. Good afternoon, Ms. Hamilton.

A. Hi.

Q. All right. My name is Adam Rodgers and I represent the personal representative for Cpl. Lionel Desmond, his sister, Cassandra Desmond. So I just have a few questions for you. I know you've answered many questions already and it's been very thorough, so I appreciate that. It's been insightful.

I just want to touch on a few issues, Ms. Hamilton. The first one I'll start with is the discussion of Cpl. Desmond talking about wishing and wanting to be a good father, but perhaps not having a nuanced or in-depth understanding of what that means or maybe just not being able to express it. So I guess that's the ... So what you said certainly made some sense to me, which is, you know, Cpl. Desmond's father was absent throughout his childhood and he, himself, was away from his own daughter for most of her life and so wasn't ... didn't have his own personal experience, perhaps, not a great deal of it. He

did grow up in a multigenerational home where his grandfather was present, and his grandfather, we've heard earlier, had 22 children so, certainly, would've gained perhaps some insight or observed some fathering, some parenting, at that stage.

So I guess my question is, was this something, I guess, that you concluded based on your conversation, or that he didn't understand it, or that he couldn't articulate it?

(15:20)

A. At the time, it was my ... I think it was a bit of both. I thought that he was having trouble articulating it, in part, because he hadn't had a lot of experience and time with his daughter. I think he was capable of understanding. If we'd really gone ... you know, if he'd gone through ... this is ... different ideas of what a father was. I think the understanding part was there. He just simply didn't have a clear idea of what he thought a good father was.

Q. Where might he gain some of that insight? Is this something that you worked with him to, you know, to establish what it might mean to be a good father? Is it something where you would wish him to speak to some friends of his that had children? What would you have recommended for him?

A. That would've been part of it, talking to the friends

who had kids and how they ... it's something that may have happened in groups naturally. And then the other way really was just ongoing discussions with him about what kind of things do you enjoy doing? What does she enjoy doing? And is there something that, you know, where can you find a link with her that can allow you to start to build a relationship? And it did eventually culminate in him choosing an activity he could do with her to try to work on that.

Q. Yes. I think ... and there was some evidence I think we've heard too that they did go ... she was involved in horseback riding sometime after ...

A. Mm-hmm.

Q. ... he returned. I wonder whether, Ms. Hamilton, it may also have had to do with some brain injuries that he had, some concussions that he suffered, and just inability or diminished ability to articulate himself and form his thoughts in that manner. Is that something that you observed in him?

A. I think it certainly could've been one explanation. You know, we did feel, as I said, the more exploration into what role those different things were playing, if any, was important to understand where his challenges were.

Q. A question on your intake survey with him. It's on

page 241. I don't think we need to go to it, but you note that he didn't go to church or he didn't identify that he was a churchgoer. Is this something that you recall would've been just a quick question and answer or was that something that you might've discussed with him?

A. I believe it probably was more of, as we're going through it, just saying, Okay, and what are some other sources? And are you religious? Do you follow any particular faith? And he would've responded as I put in the report.

Q. Okay.

A. So rather quick.

Q. So we've heard also that his family was - and his mother, particularly - was a churchgoer and a regular churchgoer. Also, two days prior to the tragedy he, seemingly, out of ... you know, he went to church for, I think we've seen, the first time, that there's any evidence of at least. Is that something that you've noticed in veterans coming through for treatment, you know, a rediscovery or re-engagement with a spiritual life or spiritual self?

A. I think for those who have a belief system that involves a religion or a faith of some kind, sometimes they choose ... it sort of reignites while they're with us, but it's

not uncommon, it's not common. It's just some of them turn more to faith as a source of support and some do not.

Q. Well, if it's not common, you may not be able to answer this, but would it be re-engaging with the faith or re-engaging with a new community and a new, potential support system?

A. Well, certainly, that would be one of the things that we would discuss if someone does have a history, does have a belief system, or, you know, a church or a faith that they feel ... that they believe in, then we would encourage them to get involved because it does provide exactly that - another source of social support, another contact, another area, that you can get support from.

Q. Another support system you mentioned was a cycling group, that Cpl. Desmond enjoyed cycling. I believe he had been a runner, but, through some back injuries, he was looking for something a little more low-impact, and cycling was a good fit for him. Just a question. Around the Ste. Anne's facility, was it a good spot for cycling? It's not an urban ... is it an urban setting?

A. Yes, it's a great spot, actually, yes.

Q. Okay.

A. Yeah.

Q. It just so happened that there was a cycling shop that opened in Antigonish just a few years prior to your dealings with Cpl. Desmond. Was that something that you encouraged him to seek out himself, research, or was this something that you might expect him to work on with a case worker? How would you expect that to unfold or hope that to unfold?

A. I usually try to go for both routes. So I work with the individual and say, You know, this is something that you've identified as being helpful to you, so in your community, when you return home, you know, what are the different areas that you could look at in order to keep using this strategy? And then I will often back that up by including in my report that the client and I have discussed that it might be beneficial for him to do this. So, in that way, I feel that the client has their responsibility. They will hopefully follow up, but if they don't, then the team has the information saying, This is something that they discussed as being potentially helpful, so they might be able to help him or at least ask him, Have you done anything towards this objective that you named with the team?

Q. So, certainly, the physical activity must've been something that was encouraged by everyone. We've heard it from other professionals as well that that would be a good way to

maintain good mental health or stable ...

A. Mm-hmm.

Q. ... mental health.

Another ... I'm jumping topics a little bit because, like I say, you've answered a lot of questions already and been thorough, but you mentioned something that seemed to recur which you'd noted as a fear of abandonment. In other words, Cpl. Desmond would say, you know, I'm going to do ... you know, he would say something hoping to get a reaction from his wife to, you know, come to the rescue or say, Oh, no, no, I'll give you the reassurance that you're looking for. Is that an uncommon condition or experience in what you've observed from others as well or is this something very specific to Cpl. Desmond?

A. No, it's not uncommon at all for someone who has borderline personality traits. It would be quite typical. He didn't have a diagnosis of borderline personality disorder, but I believe that Dr. Gagnon had mentioned in some of her notes that she felt he maybe had some of those traits. So that behaviour is not at all uncommon.

Q. And don't feel ... I don't want to push you beyond your expertise, Ms. Hamilton but, you know, when that reassurance doesn't come, is that something you've seen and how does that

typically manifest itself?

A. Well, it is a little bit beyond my expertise but I can say that, to my knowledge ... it's a difficult question to answer because someone might do something just to prove that they weren't bluffing, so-to-speak, but, most of the time, if the profile that we've identified is correct, then a lot of the time, it is ... the threat is there, but the fear, the follow-through, is not. But, like I said before, it's an extremely delicate thing for a clinician to try to navigate. Okay, we know this is probably behavioural, this is probably not going to be followed through, but to not respond, it's extremely delicate.

Q. It's a difficult question, I think, for us as well, Ms. Hamilton, and I don't need a response from you, but we've seen evidence that there's been multiple times where they've discussed relationship issues and the threat of separation and divorce has been there, there was some evidence that, actually, on the day of, on January 3rd, that there was a discussion that was reflected through a counsellor that there might've been more of a final discussion on when it came to divorce between the two. So I just wanted to see if you had any reflections on that. I don't need you to comment on that. I just wanted to ... that's why I was asking the question.

So if I understand correctly, Ms. Hamilton, ideally, from your perspective, Cpl. Desmond would've left Ste. Anne's. People knew he was going back to Nova Scotia but, in your view, the best thing for him maybe would've gone back to an apartment or to a separate residence, perhaps, begin a dating - if we want to call it dating his wife again, getting slowly back, integrated back into the family while still working on his own conditions and his own issues? That would've been a ...

A. That would've been my recommendation, yes.

Q. All, again, with the proper supports in place and the continuity of care that you've talked about already.

We've heard evidence that he did have a place to go, his aunt's house to go to, but that's not quite what you're talking about. That's not quite as good, would it be?

A. Sorry, I didn't understand that last bit.

(15:30)

Q. Oh, sorry. He was living in the home. He had a place where he could go if things were getting bad, like, another ... a bed that he could stay in at his aunt's place but, in your view, that wouldn't be quite as good as having your own place and then slowly reintegrating into the family. Would that be your view on that?

A. Yes, I would've ... yeah, I think it would've ... I mean, having a place to go would've been very important, so, at the very least, having a place to go, that would be good, but having his own space, for a variety of ... all the ones that we mentioned, but also the fact that in his anger management strategies, he named that his primary strategy was walking away. And so if you're going to walk away, you need to have a place you can walk to, and it seemed very vital that he have his own space that when things got too much, he'd be able to have a place to go in order to regulate his emotions.

Q. And, finally, Ms. Hamilton, you mentioned that you, when you're doing the discharge, you talk to the case manager and you always invite them to call if something comes up, if you need to, you know, discuss the diagnosis, refine anything, or for whatever reason, I guess. Is that the invitation you provide?

A. Yes. In the course of the teleconference, we'll mention that they're welcome to call us at any time for questions.

Q. Do people call?

A. Pardon me?

Q. Do people call? Do care providers, case managers, do people call back to ask questions?

A. I ... sometimes. I'm not the one they call. They would call the admissions nurse and then it would get referred to me if there's any further questions, but in the time that I've been there, I haven't gotten many ... any calls back after a person has left. Not many.

Q. Okay. And, specifically, in Cpl. Desmond's case, did his case manager or anybody else call to ask any questions or get any ... provide any updates or ...

A. Not ...

Q. ... just discuss his care?

A. Not that I'm aware of. There may have been calls made to the clinical coordinator or to the admissions nurse, but I didn't get any information on that.

Q. Okay, thank you very much, Ms. Hamilton. Appreciate that. Those are all the questions I have.

A. Thank you.

THE COURT: Mr. MacKenzie?

MR. MACKENZIE: No questions, Your Honour.

THE COURT: Thank you. Ms. MacGregor?

MS. MACGREGOR: No questions, Your Honour.

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

MS. GRANT: Thank you, Your Honour.

CROSS-EXAMINATION BY MS. GRANT

(15:33)

MS. GRANT: Good afternoon, Ms. Hamilton. Can you hear me?

A. Good afternoon.

Q. Hi. My name is Melissa Grant and I'm representing the Government of Canada, including the various federal entities such as Veterans Affairs and the Canadian Armed Forces. Just a couple of questions for you today.

Would you agree that there was no formal recommendation from the interdisciplinary team for Lionel Desmond's family to visit as part of his treatment plan?

A. On the discharge summary? No, there was no formal recommendation of that.

Q. And looking at the clinical care manager, that was a recommendation that was made. In this case, and you're probably not aware of this, but the clinical care manager that was set up for Mr. Desmond later on was a social worker, so, like yourself. So based on your information about what you know about a clinical care manager, that person doesn't actually provide care, health

care. Is that ...

A. Not that I ... no. I think that they're really literally coordinators of services. They ... I think some of them will work more directly with the person to help identify what they need but, often, they're making sure that they have the services they need.

Q. Okay. And so in that vein and sort of thinking about some of the other issues we discussed earlier about the cycling and that sort of thing, one might expect a clinical care manager to locate, perhaps, a cycling club, but couldn't actually make Mr. Desmond attend that cycling club.

A. Correct.

Q. And ...

A. And even, I would add to that, even in the location of, it would be important to do that in collaboration with the client, with Mr. Desmond, to sit down with him and go online and say, Okay, so where is this? And then once the information ... once they get him moving - And, oh, you found this information - then he would take over in the contacting and the setting it up. She'd follow up and see if he needed more support but he would be the one to actually go through the process.

Q. And, similarly, there's been discussion of Mr. Desmond

lacking, I guess, a robust support network, if I could ... social support network, if I could put it that way. And, again, with respect to a clinical care manager, there's not really an ability, I guess, would you agree, for that person, or really any care manager or case manager, to manufacture a support network for a person.

A. No. That wouldn't be their role.

Q. Thank you. Looking at the situation with Mr. Desmond and the fact that the referring team from the New Brunswick OSI clinic did not take him back, would you agree that that was a really unusual situation?

A. It was definitely, yeah, it was nothing ... I know that that team didn't want things to go that way, and we certainly didn't recommend that that happen the way that it happened. So, yeah, no. Normally, the person is referred to us by the treating team, they spend time in our program, and then when they discharge, they go back to their treating team with those recommendations that we send. So it, to my knowledge, has never happened, in the time that I've been there, that the discharge coincides with moving to a different external team.

Q. And in this particular case, not only did Mr. Desmond move to a new place, but it was a place that didn't have an OSI

clinic like the one that he had left in Fredericton. Correct? To your understanding.

A. Yeah, well, I wasn't aware of that at the time that he moved but I am now.

Q. And you had expressed your concerns about a lot of these stressors being potentially a lot. That it was a lot of change all at the same time.

A. Mm-hmm.

Q. And do you think that, in that circumstance, would it have been beneficial for Mr. Desmond to access the services offered by the closest OSI clinic, which would have been in Halifax, that that would've offered him some support?

A. Sure, yes, if he could've accessed it, I think any form of support would've been helpful.

Q. So similar to the New Brunswick OSI, there would've been access to those interdisciplinary and multidisciplinary team approach.

A. Mm-hmm, yes.

Q. Some of the questions that you were asked were kind of prefaced with the "ideally in this situation" or "ideally in that situation", and I guess I would just ask your comment with respect to the reality that sometimes people make decisions that

are not in their own best interest. Would you agree with that?

A. Yes.

Q. And how do you ...

A. And they can be difficult to ...

Q. Go ahead.

A. Sorry. It can be difficult to not want to say, Don't do that, do this, but we can't do that.

Q. So that's not part of your role.

A. No, and it wouldn't ... it's not the best approach anyway to be overly authoritative.

Q. Right, because sometimes that could potentially backfire and maybe a person would be less likely to do the thing that maybe is in their own best interest.

A. Well, I think it can be a number of things. It could be that. It could be someone who says, No, you're not going to tell me what to do, and do the opposite, or it could be someone who doesn't have confidence in their ability to make decisions for themselves, so they will do exactly what they're told, but then they won't know what to do next because they need someone to make that decision for them.

Q. Right. Thank you. So in the discharge report, you had said earlier that one of the ... I think you said one of the

primary ... or what was of primary importance was exploring what, potentially, was blocking Mr. Desmond's ability to maybe process the kinds of treatments you were offering, and that's what led to the neuropsych assessment recommendation.

A. Yes.

Q. Yeah.

A. Yeah, neuropsych and psychometrics as well.

Q. But you'd agree that you also said that in the list of recommendations, there was no sort of list of priorities, that they weren't prioritized.

A. No, that's true.

Q. Okay. There's a bit of maybe existing confusion I'm wondering if you could clear up which is, number one, the typical length of the program, so stabilization plus residential. Is there a typical length of stay?

(15:40)

A. There is. It does vary, but, typically, the stabilization phase is approximately four weeks. That one has more variation. It can be four weeks, six weeks, sometimes even eight weeks, but, typically, four weeks. And then the residential is eight weeks.

Q. Okay.

A. And that one is (inaudible - audio).

Q. So if there's been a suggestion, whether here or reported in other sources, that it was supposed to be six months, that's not accurate. Correct?

A. No, that's not accurate.

Q. Thank you. One more question which is maybe ... oh, and, I guess, following that, there's also been some suggestion in the records that Mr. Desmond left the residential phase early. Is that correct or what do you understand to be the case about that?

A. Yes, that is correct. He left one week earlier than his discharge date as it was planned. They usually pick the discharge date when they transfer to residential, so it'll be eight weeks after the date of transfer and, in his case, he chose to leave one week ahead of time.

Q. Okay, thank you for that clarification. One last question that may be difficult to answer, and it's fair if you can't, but there's been ... sort of about viewing things through a certain lens, and as my friend, Mr. Russell, was talking about, you know, there's the military lens, and then also you were asked a couple of questions about, you know, a racial lens.

A. Mm-hmm.

Q. In this case, I'm kind of interested in a gender lens, and I guess my question is, is it sometimes more difficult for men to access mental health care services?

A. Globally or within the military population?

Q. Globally.

A. I think that's probably a fair ... I don't have any statistics to back me up on that, but my instinct would be to say yes, I think women, generally, are more comfortable seeking out help.

Q. And, similarly, what about developing that sort of strong social support structure where you can, you know, talk to a friend about things that are going on that are really kind of deep and not really superficial. Do you find that maybe men have more of a difficulty with that as well on a global kind of scale?

A. Yeah, I do believe that to be the case. And, again, I haven't done any research projects on it, but I have read a number of things that talks about that being an issue for men, particularly once they're graduated university and they no longer have friends sort of right next to them every day, that they become ... they have ... their contacts are their families and they don't have many friends outside of that, whereas women tend to continue to make links and continue to have those groups and

social supports.

Q. Okay. Thank you very much. Those are all my questions.

A. Thank you.

THE COURT: Thank you, Ms. Grant. Mr. Russell?

MR. RUSSELL: Yes, Your Honour. I'm not sure if Ms. Hamilton's counsel has any questions, and after that point, before the witness is let go, there's a procedural question. If we take a break, the procedural question was regarding, there was a series of questions regarding malarial medication that Lionel Desmond would have taken while in the Canadian Armed Forces.

THE COURT: Mm-hmm.

MR. RUSSELL: Our federal colleagues have answered what medication he had been taking, and the question is, clearly, Ms. Hamilton won't be able ... she's not familiar with the document, so she wouldn't be able to speak to it, but perhaps the procedure would be to have it entered as an exhibit, what medication it was and when it was administered.

THE COURT: As I understand it, Ms. Hamilton was asked whether or not Mr. Desmond had mentioned the type of medication that he had taken, the anti-malarial - and, presumably, that was when he was deployed overseas - and he did not answer the

question. So we don't know what it was. Are you suggesting, Ms. Ward, that there's a document that would say what it was and you're prepared to just put that ... have that document entered? Is that the idea?

MS. WARD: I think, Your Honour, that it's more than just what he was prescribed. I think that the witnesses had talked about his relating his reaction to what he was prescribed.

THE COURT: Right.

MS. WARD: And this document goes some way toward explaining what exactly happened when he took his first dose of this medication and it's somewhat at odds with what he reported, so ...

THE COURT: All right, but, just in ... all right. So just in relation to Ms. Hamilton, that discussion really doesn't relate to her evidence. Am I correct?

MS. WARD: True.

EXAMINATION BY THE COURT

(15:46)

THE COURT: All right, thank you. I have a couple of questions that are just brief, I think.

Ms. Hamilton, I just want to ask you about your employment

experience prior to joining the clinic at Ste. Anne's Hospital. I understand that from January 2008 to April 2016, you were a social worker at Douglas Mental Health University Institute, is that correct?

A. Yes, I was. That's correct.

Q. And Ste. Anne's Hospital, is it a separate entity from the University Health Institute system? Is it a separate entity?

A. Both organizations are part of the same overarching, there's this (French term) like an integrated ... I don't know the English word of ...

MR. CHABOT: It's an integrated university health centre, basically, that encompasses many different health establishments. Ste. Anne and Douglas fall under the same entity.

THE COURT: All right. And you were a social worker while you were engaged at the Douglas Mental Health University Institute and you were involved in evaluation and integration of clients, development and animation of group activities and individual supports. When you ... I take it that you applied for a position at Ste. Anne's? Am I correct?

A. Yes. Yes, I did.

Q. And who would have, I'm going to use the word "hired" you to work at Ste. Anne's? Can you tell me how that decision came about?

A. I went to the interview. I had, like, several years of working in mental health. Not with PTSD, but in depression, anxiety, working with people with different difficulties, and I also had experience as a member of the Reserves which I think helps a little bit, given the knowledge of military culture and, as such, they chose to hire me.

Q. You had worked kind of actively with patients such as you did in the clinic prior to joining the clinic? Is that correct?

A. Prior to joining the Ste. Anne's ...

Q. Yes.

A. ... I worked with a different ... yeah, I worked with a different type of clientele - people with schizophrenia, bipolar disorder, and anxiety, depression, related to those diagnoses.

Q. All right, thank you.

When you have a client or a patient at Ste. Anne's and they complete the term of treatment that's there, I take it that the expectation is that when they're released, they would return to the care of an outside treatment team once they're discharged,

and that that treatment team would generally pick up where you had left off; that is, the clinic had left off, and would take into account the recommendations that were contained in the discharge report and also take note of whatever information or recommendations might be contained in the closing notes as well that would generally be expected to accompany the discharge report. Is that correct?

A. Yes, that is correct.

Q. All right. And the information; that is, the summary and the closing notes, would also go to VAC?

A. To the VAC case manager, yes.

Q. That would go to the VAC ...

A. They would get a copy.

Q. ... case manager, I take it, as well, with some expectation that the VAC case manager would look at and review that information and be involved in the coordination of whatever additional - I'm going to use the word generally - supports that might be recommended and/or available to the discharged client/patient. Would that be correct as well?

(15:50)

A. I'm sorry, I didn't ...

Q. Well ...

A. I'm ...

Q. ... you send the summary and the closing notes to VAC, to the case manager, with ...

A. Yes.

Q. ... some expectation. There's some reason they're sent. What would be your expectation when the discharge report and the closing notes are sent to the case manager? What would you expect the case manager's role would be?

A. The case manager's role, oftentimes, is to approve those services. So the OSI clinic will recommend or will follow through on the recommendations but, to my knowledge, which is not vast of how VAC functions, is that the case manager is in a position to approve those ... that the member receives those services.

Q. Oh, I see. All right. And if, in this case, an individual went back to OSI New Brunswick, for instance, and there was some additional services that might be required, the case manager would have documentation available to them at that time to understand ...

A. Yes.

Q. ... to understand why those services might be requested. I see.

So I'm going to ask you one last question, and right at the end, I'm going to ask you whether or not you want to answer it or not, or if you can, think you can, answer it. Okay? So when I listened to your evidence, you ... and I've heard some evidence before when you talk about the issue of control and vulnerability. And so when a person is feeling vulnerable, it might trigger something, may trigger their anger. So the feeling of vulnerability might trigger anger, and anger is used as a way to gain control. Do I understand that correctly? That's a ...

A. Yes.

Q. ... known mechanism in that regard?

A. Yes.

Q. Yes. All right.

A. Yes.

Q. So vulnerability can trigger anger as a way to regain, or a person think they've regained, control of a situation. At the same time, you have another kind of a concept of an underlying fear of abandonment and, you know, I think you've identified that Cpl. Desmond had an underlying fear of abandonment. Am I correct?

A. I believe so, yes. That was my impression.

Q. Okay. So a feeling of abandonment would make one feel

vulnerable.

A. That's fair to say, yeah.

Q. I think we'd all agree with that. All right. So ... and if you're feeling abandoned or you're feeling vulnerable, and the feeling of abandonment comes about as a result of circumstances where ... and this is ... we don't know this exactly, but it's a bit hypothetical, but some of it is ... I think we have some facts to support it as well. If part of the feeling of vulnerability and abandonment comes about because there's an event and Shanna Desmond says, I want you to leave the house and I don't want you to come back. Either don't come back or come back until you're well. Go to the hospital. Get yourself fixed up. And I want a divorce. He heads off to the hospital and comes back and he can't go back to his home now. I would suggest that at that point in time he would feel not only vulnerable but certainly abandoned. Would I ...

A. I would agree, yes.

Q. You wouldn't disagree with that. All right. So he needs to, at that point in time, regain control. And he's probably ... maybe as desperate as he's ever been. So, at that point in time, to regain control - and this is my question - have you seen or read or have any knowledge of whether or not, in a

circumstance like that, where suicide becomes the ultimate act of control? If you can answer it. That's fine if you can't.

A. In a person ... it's possible, yes. And, you know, this is all theoretical, but, yes, it's possible, if a person is feeling that desperate, that, yes, ending things permanently would be an ultimate sense of, I can control this situation. And I also ... and I speak from ... not from years of experience of working with personality disorders or any of those things, but for someone who has lived with a chronic fear of being abandoned, if, indeed, that's what we observed, if that was accurate that he had lived with that, then the actual imminent threat of being abandoned would have served as a very ... as a tremendous trigger.

Q. Thank you, Ms. Hamilton, I appreciate ...

A. Thank you ...

Q. ... turning your attention to that.

I also would like to thank you for your time and I know your counsel is there and the time that was put in ... dedicated by you to meeting and having discussions with counsel and reviewing the documents and refreshing your memory and taking us back to the circumstances, as you actually experienced them with Cpl. Desmond at the time that he was at Ste. Anne's Hospital. I

appreciate that it's not all ... would not always be easy to do that. So, again, so thank you for your time and your consideration. We appreciate it.

A. Thank you very much.

THE COURT: Thank you.

MR. CHABOT: Thank you, Your Honour.

THE COURT: All right, thank you.

WITNESS WITHDREW (15:56 hrs.)

THE COURT: Thank you, Counsel. We'll adjourn in a moment. I think Ms. Hamilton is gone. You've cut the link to Ms. Hamilton. Thank you. And Ms. Ward?

MS. WARD: Your Honour, here's the situation. So ...

THE COURT: Would you like to have this as a Chambers' discussion?

MS. WARD: Perhaps that would be appropriate.

THE COURT: All right, thank you. So we'll adjourn for the day, unless we return in a few moments' time. Thank you. And so I'm going to adjourn until tomorrow morning at 9:30 unless we're re-called this afternoon. Thank you.

COURT CLOSED (15:57 HRS)

CERTIFICATE OF COURT TRANSCRIBER

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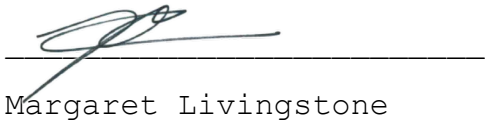

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