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 24, 2021

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

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

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

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

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

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

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

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

Karl Chabot, Esq.
Counsel for Julie Beauchesne, Maria Riccardi and Julie Blondin

NOTICE TO READER

INAUDIBLES DUE TO QUALITY/VOLUME OF AUDIO/VIDEO RECORDING

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EXHIBIT LIST

March 24, 2021

COURT OPENED (09:46 HRS.)

THE COURT: Thank you. Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Good morning, Ms. Beauchesne. How are you today?

MS. BEAUCHESNE: Good morning. Thank you. How are you?

THE COURT: I'm fine, thank you. Mr. Chabot, thank you. Good to see you again.

MR. CHABOT: Good morning.

THE COURT: Perhaps we could swear the witness and then we'll begin, Mr. Russell, I take it.

JULIE BEAUCHESNE, affirmed, testified:

THE COURT: Mr. Russell?

I might say that before we begin, I checked on the website yesterday, I went back last night, and I reviewed the video evidence that we have from Ms. Beauchesne from the last date and I don't know if you had intended to go over some of the material that you had touched base on on the last date.

The audio is not bad until you get to the very end and then it muffles off, and I think that was the point where we stopped and there's no transcript been posted of that evidence yet. But in my view the audio was sufficient that we should be able to have a transcript of it as well. So, thank you.

MR. RUSSELL: Yes, Your Honour. I would briefly just sort of restart. I wouldn't go on as much detail in terms of background, but just to keep a flow of a direct examination.

THE COURT: Thank you.

DIRECT EXAMINATION

MR. RUSSELL: Hello again, Ms. Beauchesne.

A. Hello.

Q. So I'll probably start back at the beginning a little

bit to make it sort of easier, the dynamic question and answer. So again, if you could just begin by saying your full name for the Court.

A. Julie Beauchesne.

EXHIBIT P000272 - *CURRICULUM VITAE* OF JULIE BEAUCHESNE

Q. And if we could start by ... there was an Exhibit 272, which is a copy of your *CV*.

A. Yes.

Q. I don't plan on going into in great detail, but I would ... just if you could outline for us a little bit about we know that you're an occupational therapist, when did you graduate with your degree?

A. In August 2005.

Q. And since 2005, since graduating as an occupational therapist, where have you been employed?

A. Most of the time I've been employed at Ste. Anne's Hospital working with their geriatric population in their long-term care facility at Ste. Anne Hospital. But since 2007 I've been involved with the population that I work with now, which is military veterans suffering from OSI condition.

(09:50)

Q. I understand that you are currently clinical

coordinator at Ste. Anne's?

A. Yes.

Q. How long have you been the clinical coordinator?

A. Since 2017 after having taken the position of manager for the clinic for about a year or a bit more.

Q. Do you still perform your roles as an occupational therapist similar to what you had done in 2016 or has that changed?

A. It's changed in the sense that I do carry out the role of OT but in different ways. I do still coordinate some groups more in a punctual manner. I don't have a set caseload as an OT. I have a caseload as a clinical coordinator following up with the evolution, the progress and the treatment when people come in.

So that's my caseload as a clinical coordinator, all 10 clients that we have. But I'm not as involved, for instance, in individual follow-ups, although I could still, if I have time or if there is a need or if our other OT which works with us is not available I could proceed to meet with clients.

Q. So in terms of your career, is it fair to say that you've spent the majority of your time dealing with clients with military background?

A. Yes, absolutely. Yes.

Q. What is an occupational therapist? If you could just sort of define what an occupational therapist is and what sort of is your role in the administration of health services.

A. Okay. Well, occupational therapy is a health practitioner that practices in the field of rehabilitation. So in occupational therapy we work with people of varied age ranges that have functional issues the result of psychiatric or physical condition, that's mostly what it is.

Occupational therapy in mental health we would say is in the field of psychosocial rehabilitation. The main goal of the follow-up in occupational therapy is always the same no matter who you're dealing with and what the challenges are with regard to participation in activity.

The goal is always the same, is to have ... to provide intervention and treatment ... or to assess first and then to provide intervention and treatment to help a person live the most meaningful life possible, be able to overcome the barriers and the challenges they're facing as a result of their condition.

Q. So if I get this right, so an occupational therapist in a mental health services model ...

A. Mm-hmm. Yes.

Q. ... is focussed on psychosocial rehabilitation?

A. Yes. Mostly.

Q. And what exactly ... mostly. So what exactly is psychosocial rehabilitation?

A. Okay. Well because it refers to the fact that in mental health the barriers would be different than with physical rehabilitation. So in mental health the barriers would be related to psychiatric condition, mental health problems and their associated consequences.

So that's why I was referring to psychosocial rehabilitation because we're going to be dealing with barriers in terms of symptoms interfering with the participation, with symptoms that can be also cognitive problems, symptoms as it affect the people's capacity to interact with others.

(We're given?) the symptoms that end up resulting in difficulties for the people to self-manage, to self-regulate their emotions. So these kinds of challenges are the ones that are getting the focus of ability to look at and to see how these are interfering with the person being able to do the things that they have to do, the things that they want to do, the things that they're expected to do. And, you know, we're going to help

and find strategies to help the person again deal with those challenges in a way that they interfere less or not anymore.

Q. If you can give sort of -- in your experience dealing with military veterans in a mental health context, what are some barriers or struggles that you see that are fairly frequent and common in their psychosocial? What sort of challenges?

A. What sort of challenges? With the military population, veteran population, there is very specific challenges, most ... well, they're specific, yeah, challenges there. Anything that has to do with challenges related to being, for instance, released from the Forces. The impact on the life of person that's been released from the Forces. The impact on their family that it's going to have.

Challenges can be relationship challenges, there can be loss of identity because they've lost a primarily very significant role of the military becoming a civilian, especially when it's not their choice, when it's a release for a medical condition.

So challenges also can be coming to terms with having to deal with a mental health diagnosis and all of its consequences. Accepting them, the situation. Challenges also more against specific to military. It's coming out of a very structured

context and, you know, finding yourself now in a civilian life, to have to deal with organizing yourself and structuring your own life in a way that you're able to carry out the things you want to do. Even identifying what those things are at this point after the loss of that role.

The loss of also the comradeship. The loss of a primary social support network. So there's many issues, yeah, that ... just that ... not just that because I don't want to minimize anything but transition to civilian life comprises all kinds of challenges that we're going to deal with. Stress management, anxiety management, understanding how ... you know, having been in the military has shaped one's perspective vision of the world, vision of how to go about things, all these kind of things. So there's going to be a lot of different areas that we're going to cover.

Q. So is it fair to say that there's some aspects that are unique to military veterans that are dealing with mental health and struggles, especially within that context of transitioning from military to civilian life?

A. Yes, it's important to have a military cultural competence (inaudible) because you need to have that understanding of what the person's coming from because military

being like a subculture. You need to understand where ... how that again shaped the experience of a person, how it's shaping their experience, how they're transitioning also to civilian life.

You need to understand again the ... what it involves for them and their family and their close ones (by?) all those changes.

You need to understand also in terms of the experiences, when we're talking about like trauma, also to have a trauma-informed practice as an OT as a team. There's (inaudible) specific trauma work can be done in psychotherapy, psychologists, so, yeah, but as a team when working with ... as a team or an individual working with that population you have to integrate that into your approach to really have like a general competency ... understanding of how the experience of military with trauma will most likely be different from experiences in the civilian life with trauma where it will have been oftentimes trauma repeated over a long period of time.

So yeah, there's specific aspects like that that become like specific skills or knowledge that should be ... that they need to be considered. So you want to really work and have an impact on how the client center (inaudible) with military and

veterans.

Q. So in your experience at Ste. Anne's and dealing with a number of military veterans over those period of years, there are sort of I guess, two concepts. There's the circle of care, which is various mental health practitioners wrapping around a client, and there's the concept of continuity of care which is sort of a continuation from one health services provider to the other.

A. Mm-hmm.

Q. How common is it that you've seen that when a military veteran leaves Ste. Anne's that there is a need for a continued circle of care and a continued continuity of care? Is that something that's very frequent or is it sort of ...

A. Pardon me? If it's? Can you just repeat that?

Q. How common is it?

A. It's essential. It's not only common it's essential. It's planned to be that way because we even expect ... we more than expect it, we ask when a person is admitted that there will be people waiting for that person when they get out. So that there will be a treating team in place. That treating team may be a different format depending on the situation but because we believe that element to be essential for the recovery process,

for the person not to fall between (inaudible), it's not only common but it's essential at the time and expected that it would be organized in that way.

(10:00)

Q. And when you say ... I guess we'll turn it now specifically to Lionel Desmond. So you would have seen Lionel Desmond at the clinic in Ste. Anne's, I'm assuming, in 2016.

A. Yes.

Q. Were you able to sort of give us an idea of when you first ... for approximately how long you would have seen him, between what dates?

A. Well, I seen him, probably, on a daily basis every time I was at work during that time because I was on the unit. So I was transitioning, myself, between the role of OT and the managerial role. And I've seen him in groups. I've seen him at individual sessions. But I know for sure at least six times because of my notes. I know that I have seen him when I administered a screening tool for cognitive functioning.

I've seen him, also, that I know for sure on at least another two occasions with other members of the team in situations where he was struggling, having challenges with self-regulation in some different situations, but I'm not even

exactly sure what they were. I just remember being at those meetings and offering support alongside my colleagues to Mr. Desmond.

So I've seen him quite a lot so ... yeah, in that context, but specifically in OT sessions I can't recall exactly the number of times.

Q. So we know he was admitted to Ste. Anne's on May 30th and he's discharged August 15th and there were two phases. There was the stabilization phase and residential phase. So would you have interacted with him basically from the sort of very beginning through to the end on both phases?

A. Yes. Yes, because I think I was involved in animating some groups. Systematically, I would have seen him. He would have seen me in that context systematically from the beginning.

Q. So I'm going to get into sort of your impressions of him generally and then move to specifics.

A. Mm-hmm.

Q. But before I do. You indicated you saw him in group settings and individual settings. If you could tell us a little bit about, I guess, the importance of why there are group settings and individual settings as it relates to Lionel Desmond. What are they and why the two different types?

A. Okay. Why the combination of both type of setting?

Q. Yes.

A. The programs are structured this way for allowing for a varied types of therapeutic opportunities. Both types of setting having sharing some similar aspects, some similar opportunity but also distinct ones. There is also the fact ... and I'll come back to that. But there's also the fact that having programming, having groups is a way also to structure the routine, to structure the days when people come back ... come for treatment.

Because one of the components of being in a residential program is that structure that's "(French term) therapie" is where the behavioural reactivation component. So, you know, having a reason to get up in the morning. Having a preestablished schedule. So that's one of the reasons, also, of all those groups being there. Then if you go more specifically of, you know, the contents of the groups have been specifically determined to meet the needs of the clients, the common need of the clients.

So group setting will offer opportunities for (inaudible) for peer support, first of all. It's also a place where people can share openly and learn from the experiences of their peers.

In group settings the role of the therapist would be one of ... well, it could be psychotherapy if it's a psychotherapy group. But the ones I was animating, for instance, are more educating, counselling, support. It could be tight groups. So there is that interaction, that place where people can share experiences, again, learn from each other.

In an individual setting, then it's meant to be a safe place also where people can feel maybe freer sometimes. It's easier for them on a one-to-one basis to share some elements of their experience and grow in that setting. So it's the combination to allow patients to gain the most out of a variety of opportunities ... therapeutic opportunities.

Q. We're going to get into the specifics at some point, but did Lionel Desmond appear to benefit from both group sessions and individual sessions?

A. Yes, I would say so. Yeah.

Q. When Lionel Desmond was about to leave Ste. Anne's, in terms of your overall recommendations, was it your anticipation that he was going to continue with services in both group settings and individual settings?

A. That's a good question. I'm sure he could benefit ... I'm sure he could have benefitted. I didn't recommend ... I

don't recall a specific recommendation for group therapy. I'd have to look at the summary. I don't remember, myself, mentioning group therapy but, yes, I think he could have still benefitted from different settings, yes. From those two settings, yeah.

Q. If you could tell us generally. We're going to break down the specific interactions. But what were your sort of overall impressions of Lionel Desmond and ... yeah, what were your overall impressions of Lionel Desmond in your time with him?

A. Well, I remember we addressed that a little bit the other time and by this time with the process it becomes a bit difficult to distinguish between what I remember, what I think I remember, what I know now that I didn't actually remember. But my general souvenir of Lionel Desmond was a person that was very ... it was ... he had ... it was nice to work with him. He was polite, well mannered. He had a good sense of humour. He interacted with people. He seemed to be wanting to be there with us (and work?).

I remember him expressing his motivation to get better, to get back on track and to have a life and have a life as a father, have a life as a husband. He had that project. He had

that goal. I remember him being aware that, you know, there was some elements interfering and that he had a contribution in the difficulties that were in his life.

But I also remember somebody, you know, struggling with all the challenges that he was facing, challenges regarding having to deal with ... again, what I was talking about earlier, having been released from the Forces, the losses related to that. Grieving, anger, frustration, (French term). I forget the name in English but bitterness along with the situation. Having to come to term ... well, come to terms even though he wasn't there.

But having to deal with accepting his situation, accepting all that it entailed to be where he was now. Just even coming to treatment and (inaudible) as in psychiatry was a challenge he was facing. You know, like, all the people that come and are (civilized?) in our setting. Challenges, all the psychosocial stressors, not knowing exactly what's become of his relationship, because although he was motivated it was depending on him. So a lot of ... dealing with uncertainty, all the unknown, the stress related to that. Also challenges ... well, like I said, with symptoms (from before?) how they translated.

So having ... seeing himself struggling to manage his

anxiety, struggling to manage his anger, all those challenges.

Q. So you ...

A. But ... so I do ... yes?

Q. So you touched upon sort of his motivation. How would you sort of rate his level of motivation to actually make efforts to sort of get better and improve the things he was struggling with? Low, moderate, high. Are you able to say?

A. I won't ... I'm not sure I want to rate it in that sense. Not to be rebellious.

Q. That's fair.

A. But really, for me, the fact that this person, with all the challenges that he was facing ... and I have a lot of respect for all of our clients in that way when they come. And they come to the program. Just coming in is very difficult. It shows motivation. And to remain in the program, which he did. Which he did for many weeks. So that ... parts of it is motivation. Even though I would say there was times ... again, I think I remember or I heard, I'm not sure, I know most clients will at some point question, Is this really what I should be doing? Is this the best treatment for me? Or they ... you know, they attempt something difficult and they feel like giving up.

(10:10)

But, in general, when a person stays all those weeks, you know, in itself it talks motivation to get better, motivation for recovery. It doesn't mean he was able to ... like, in every instance motivated to work in that manner with everyone in every setting. Not ... no, but overall I would say that he was motivated.

Q. How would you describe his level of insight into the various things he was struggling with? For example, we know he had PTSD. We know he was diagnosed with depression. There were diagnosis of traits of mixed personality and substance use when it came to alcohol and then things that went along with it, which were anger, emotional regulation, those sort of things.

What sort of level of insight did he have into his struggles?

A. I can't give a very specific answer. I would say for sure some insight. But different elements can interfere with the ability of a person to have insight or to demonstrate that they have insight. You know, recognizing your contribution to different situations of conflict, for instance, is very solicitating and can create pressure. So the person can be in denial and then you could say that, you know, they're not

insightful, but is it just something else?

So it's hard to tell specifically, but like, I would say for sure there was some insight. But at the same time some elements might have interfered with ... might have interfered with his capacity to have insight. And I know it was in the things that you were asking ... that you probably will address later. For instance, his pattern of thinking, how he processed information, some rigidity, cognitive rigidity there, that could also interfere with his capacity to have insight and ... looking at that. Anyway, (inaudible) things.

Q. And so for example, you mentioned cognitive rigidity. So you saw that with Lionel Desmond I'm assuming?

A. Yes, I saw that in different situation. I think I ... I think it was in one of my notes. I'm not sure. But, yes, some cognitive rigidity there, some should-type thinking, having rules ... set rules on which ... by which he ... you know, it's the lens with which he would analyze situations. So ... yeah.

Q. So what is should-type thinking? You said you saw that with Lionel Desmond. What is should-type thinking?

A. Mm-hmm. Well, we saw it with Lionel Desmond. We see this with many, many clients. As I said before, it was ... well, I said some before, I'm going to qualify. It's a reverse

of a thinking pattern, okay? It occurs really to the person being able to (inaudible) in situations, to take into consideration a variety of elements to analyze situations, for instance. So it would affect problem solving. It would affect how to process information. It would affect, ultimately, how the person reacts to situations.

So to give a more concrete example, in a conflict situation there would be reactions that would reflect cognitive rigidity, there'd be reactions where the person is not so able to see the contribution in the conflict, are not so able to put in perspective how they could have done things differently.

Yeah, so it can also lead to less empathy toward a person. It can lead to ... yeah, things I've already mentioned actually so it's about how the people process those things.

Q. Was Lionel Desmond ever able to achieve success in sort of either eliminating or reducing that sort of should-type thinking?

A. I can't think of a specific example, per se, but I am sure he ... yeah, I'm sure he would, because I remember, like, for instance, when we met with him ... I'm not sure of the dates. I'm not sure exactly who was there but I know that I was (inaudible) and he was struggling. He was activated. He was

having a hard time in a situation or two situations even though it was difficult for him, he needed support to regulate and to make more sense of all the elements in the situation but he benefitted from our support because I remember ... I think I remember a positive outcome where he would leave the session and tell us even later that it helped him, you know, that it made him more aware of different elements in a situation being ... helping him to calm down and to deal better with the situation.

Q. Was this something he was going to have to continue to work on after he left Ste. Anne's?

A. Undoubtedly, yes.

Q. And how ... One, I guess, at Ste. Anne's what did you use or what was offered to reduce the should-type thinking, the cognitive rigidity, and the inability to sort of see your role in the conflict, what did you use there that had some success and what did you sort of anticipate could have been used after he left the clinic?

A. Well, it's basically interventions to help with cognitive flexibility, interventions to make a person more self-aware. So anything ... all the components, like, of mindfulness, self-observation, are things that can be used. Anxiety-management strategies, coping skills with communication,

conflict management. Those ... yeah, are some of the ... yeah.

Q. You mentioned mindfulness.

A. Yes.

Q. The only real thing I know about mindfulness is, you know, take the time to smell the lemon to distract yourself, I guess.

A. Yes. Well, that's a good example.

Q. I wonder if you could explain what mindfulness is and how you used it with Lionel Desmond and if it was successful.

A. Yeah. Well, first of all, mindfulness is kind of a no-fail approach in the sense that it's really a practice. First of all, mindfulness is a practice. It's not a specific one-time intervention. Mindfulness is a stance. It's a practice where you learn to be in the present moment and adopt a stance of being an observer of whatever is going on within yourself or outside yourself.

It's a stance where you're practicing a non-judgmental, self-compassionate perspective. And all that, you're practicing to be able, ultimately, to make more conscious choices for yourself in how you want to do things and how you want to deal with things. So it aims at a person being less reactive, more proactive. So less reactive to things coming up and distracting

you, inner experiences coming up and distracting you. All the frenziness sometimes around also on the outside, creating, you know, emotional difficult thoughts, et cetera.

So that's what it is. It's a practice, and like I said, it's really, you know, to observe, to become more self-aware. Yeah. In one's self.

Q. And so did Lionel Desmond get assistance in sort of mindfulness ... I'm going to say training but mindfulness-type interventions at the clinic?

A. Well, in the sense that when we were inviting him to take a step back and to practice being mindful in a specific situation, I think, yes, he was able. Because when I was saying it's a no-fail approach, as far as the person is able to name what they're observing of themselves and sometimes that's a (trek?) in itself. People will say, Oh, I'm observing that I'm irritable or that I'm angry, and I shouldn't. No, no, you're observing, therefore, you're being mindful and, therefore, what are you going to use that? How is that valuable? Well, it's valuable in the sense that you can decide from now on and you'll probably have to practice but you can decide to make different choices next time. So it's non-judgmental.

So in that sense it was helpful for him. There were also

mindfulness sessions. Were they helpful for him specifically? I can't tell. I wasn't animating those sessions. I don't recall if he had specific comments on those sessions but, you know, the understanding of a person ... a person's understanding of what, really, mindfulness is will also determine how they're determining if it's useful to them. Yeah.

(10:20)

Q. So would mindfulness be a type of treatment or resource that you envision for Lionel Desmond after he left Ste. Anne's?

A. Yes, yes, but always with ... you know, it would be pertinent as long as, again, there is education, there is enough for him to be recognizing the utility of practicing mindfulness. That's how it's going to be helpful, yeah.

Q. You noted ... you said ... so in terms of some of the challenges Lionel Desmond faced, you noted anxiety and anger were two sort of prominent challenges. I wonder if you could tell us a little bit about Lionel Desmond's anxiety and anger that you had sort of observed with him?

A. Well, they were ... what I remember is their presence, struggling with the presence of a lot of anxiety, struggling with dealing with the anger that resulted from what he was

experiencing and going through. And it was difficult for him. It was difficult to him. So he was having a hard time dealing with the presence of this and so it interfered ... it prevented us from using the time with him at the clinic sometimes to go more depth in some areas.

But at the same time it was of clinical value because it showed the extent to which he needed our support to overcome that challenge. To become unstuck, to become ... so to come to the point where it would interfere less and, you know, permit him to focus on starting to problem solve and to think out more how he was going to plan his life. So those are challenges. No, but he was going through a lot. He was going through a lot.

Q. How frequent and prominent in his sort of clinical portrait was his anxiety and anger? Was it sort of a daily issue that he was struggling with or ...

A. Probably ... I would say irritability was, like, in the background. They're not too far most of the time, and anxiety all the time for sure. For sure, anxiety very level ... various level of that for sure was there (French term) ... all the time.

Q. Were you ever able to tell if it was connected to anything directly or could it have been connected to his

interpersonal relationships with others? Or did it have a specific connection to something?

A. Well, yes, it had a specific connection to all the psychosocial stressors, all the ... you know, the getting out of the clinic eventually, going back to a community and how that was going to unfold. Yes, regarding relationships, social interaction on the unit with his peers, and it was related to ... I'm kind of losing my train of thought, could you repeat the question? Sorry.

Q. So I guess I can break it down a little bit further. So you talked about his anger and anxiety were connected to several things.

A. Yeah.

Q. So was one of them connected to this idea that he was even going to leave the clinic at some point to go back to his community? Did he have anxiety over that?

A. Yes. Oh, yes, like most clients do. Because it's a very ... like some people are going to come to the clinic and they're going to call it their bunker. Some people are going to love the experience and anticipate very much having to leave eventually. Some people are going to call it at some point their prison and want to leave but stay and eventually

(inaudible) but everybody goes through a period, especially near the end most of the time, more near the end, where anxiety actually even rises up more and they'll even think that they're ... it's like a drawback and then they have to normalize that experience because, no, it's just part of, you know, that ... that transitioning.

We were talking about transitioning out, it's like transitioning from the Forces, you know? The relief, that it's also a transition when you're leaving a setting like a hospital, like our unit, where you've been for almost two months and you're going back in the community. That also is a transition for which support needs to be planned.

So for sure it's a source of anxiety, a source of stress, and for him, for Mr. Desmond, there were elements of complexity there. Wasn't sure where he was going to go. The plan became a little bit more clear near the end. He made decisions, but it was a stressful scenario. It involved many things. It involved going back and live with his wife and daughter knowing that their relationship was strained and there was, you know, fragility there and a lot of unknowns.

There was element that the team was determined initially to be the team that would take over for continuity of care. Well,

the fact that he was moving to another province made that transition a little bit more complex. So that, too, was a source of anxiety for him and probably for us, too, the team. Probably for the team in New Brunswick, too. Yeah.

Q. So did ... you described some different veterans in terms of they have, you know, irritability, anxiety, anger, you know, maybe on a plateau. But in his ... how was his towards the tail end as he's leaving? Did it go up? Did it go down? Did it stay the same? How was his level of anxiety?

A. Well, it went up.

Q. Sorry, go ahead.

A. It went up at some point. There were fluctuations. It would go up and down depending on his experiences also. Like, another example it can vary, the level of anxiety, in the same day because the person had an interaction that was difficult or because they went in a group, it was confronting, they were challenged or invited to open up on something that triggered the anxiety or triggered sadness, and other (inaudible) thoughts and other ... there is anger because they're stuck carrying the sadness that was ... you know, emerging because of discussing the different topics.

So it fluctuates a lot. It fluctuates a lot for most

people in the same day, in the same ... all throughout the program. There was that thing that I mentioned about near the end, but when he left the program for sure there was anxiety but nothing outstanding that, you know, we saw that was ... felt in contrasting with most of our clients when they're leaving.

Q. So you had indicated there were a few things that he had anxiety about when he was leaving. One, you sort of alluded to the fact of you said his external care team.

A. Mm-hmm.

Q. So do you recall that he was somewhat concerned about what was going to happen in terms of his treatment after he left?

A. Well, I remember it was an issue. I don't recall, like, a specific conversation with him about him telling or expressing his stress with continuity of care with the team. But I know that it was an issue that we discussed, like, with the team. We were concerned that it wasn't the ideal scenario.

But I think I remember him demonstrating or, you know, telling us he was pretty much on top of things. His plan was all laid out. He knew, like, all the steps. He was able to report to us all the steps he had planned from the moment he was leaving the door of the clinic to where he was going, et cetera.

So there was some control there, too.

Q. And you indicated from the team within Quebec there was some concern about that handoff when he got back into the community.

A. Yeah.

Q. What was the concern as it relates to Lionel Desmond?

A. Okay. Well, the concern was, you know, that ... it's coming back to continuity of care being an essential component. So any time there's, like, a threat to the fluidity of that, or that there is potential barriers and it being ... going as smoothly as we would want it to go, there is a concern. So we're going to work as hard as we can to plan things out in a way to ensure the smoothness of the process.

But since there was facts there that we didn't have control over, that we couldn't ... he was able to make that decision for himself to not ... you know, to have that plan that he had. So we just had to go with the flow and work to make sure that everything was taken into consideration by him and also with the external team to try to make it as best as possible.

Q. What were some of the ... you talked about sort of barriers that he was going to be facing, I guess, or challenges when he left. As it specifically relates to Lionel Desmond,

what were sort of the flagged barriers that you saw when he was going to leave?

(10:30)

A. Well, I guess ... well, apart from the followup with the treatment external team in the community, apart from the followup ... apart from the impact that that was going to have with smoothness of continuity of care, the fluidity, the other ... the aspect was, how was it going to work out once he gets in Nova Scotia and living with his wife and daughter? Because there was some tension there. There was some insecurity on both sides, his wife, himself. There was all the history they had.

So we knew it was going to be a situation that was going to be ... it was going to be challenging. Again there, everybody involved was informed of that, and again there it's ... you know, the main people concerned, Mr. Desmond and his wife, that was the plan. So our job was really to make it clear how that was going to be a challenge. Like with Kama Hamilton, I think she worked really hard with Mr. Desmond in that regard.

Q. Is it fair to say that knowing Lionel Desmond's vulnerabilities, his various diagnosis and struggles was it a concern that you wanted to sort of stay on top of the fact that he could be transient to some extent? His plan with his wife

certainly may not work out. He might need housing somewhere in some province. Was that a prominent sort of concern that needed to be sort of addressed?

A. Well, it was addressed. It was addressed anticipating that if things could not unfold how he wanted to or as planned. For sure it was addressed with the social worker to look into that with him as alternatives, you know, to have a Plan B, Plan C. That was discussed, and when he left he had to be ... like, for sure it would have been comfortable with what he had brought back to us that showed us that he had sufficient, like, control.

But it doesn't erase our concern. We still had concern, but it's a concern for anybody that leaves the program. It's a concern sometimes because people leave and they're ... you know, they did really well and they feel they're on top of things and then the concern becomes, are they going to follow through with what's recommended?

So there's always concern. There wasn't any, like, huge fear of him ... of having anything catastrophic at that point. It was just a concern. Will he be able to benefit optimally from continuity of care? Will he be able, once he's back in the community, will he still be receptive to the support that's offered? Will he still want to apply the recommendations that

he was given? Will he take into consideration the advice that was given? Will he be able to put in place Plan B or C if everything don't unfold as they ... as hoped?

Q. Would it have been sort of an optimal scenario for Lionel Desmond when he's looking at those sort of issues that he leaves and he doesn't have access to any mental health resources aside from just general access in the community for about four months?

A. Can you repeat that, please? I'm not sure I understood well the question.

Q. Well, I guess my question is when he is discharged from Ste. Anne's and he leaves an environment where he has day-to-day structures with various mental health professionals is it sort of in Lionel Desmond's best interest ... are there concerns if he's now lacking those resources in months after he leaves the clinic?

A. If there's a concern if he's lacking those resources?

Q. (Nods head "yes".)

A. Okay. Well, actually, it depends on what we're talking about because is it a concern that he's lacking the level of structure he had at the clinic? Maybe not. Because maybe that's not the component that he's benefitting most from.

Is there a concern that he lacks the support of a team, as large as a team? Maybe not. Maybe he will be fine with, you know, support offered in a different way but specifically addressing the needs that were identified and that we concluded that needed to be addressed.

So that's why it's so important in that continuity of caring to assess in his own environment how the needs that we anticipated would be ... are they still the same needs and are there other needs? Because for instance, the level of structure in the program that supports having a routine and having like a more balanced routine ... well, it's not a predictor of how the person is going to function when they return to the community, but some will be able to ... some have worked on that to prepare their leaving the program.

And a lot, you know, have worked on planning schedules for themselves, planning routines for themselves. That of course will have to be fine-tuned when they're home, but still ... and will be able to do it fine. Others will over-estimate the capacity to do so and will go home and realize that they're not able to do it at all. But in those cases usually we will have, you know, we will have given information that we think that might happen, and usually we have some cues in that regard.

But for sure, it's hard to tell exactly which components of the program are most helpful and once he's in the community what is going to have the most impact of what components he's not having in terms of followup.

Q. So let's break it down. In terms of from an occupational therapist's standpoint relating to Lionel Desmond specifically, not generally. Lionel Desmond.

A. Okay.

Q. Did he need sort of assistance in structuring his day-to-day routine and keeping appointments and keeping on top of his mental health?

A. Well, in our setting?

Q. Yes.

A. It didn't seem so. When he was going back to community with all the challenges that were there I'm ... yes, from an OT perspective, for sure it was going to help. For sure it can help to have support to deal with the stressors and to have him have as less impact as possible on him being able to have a routine.

Because it was going to ... it would be the foundation for the rest, and if he's able to have some form of structure that will allow him to better organize himself and profit of his ...

you know, be able to go to his appointments, to do his followups.

So for sure it would be beneficial to see. And it'd only once he's back there that an OT assessment can simply be able to assess the level of assistance he needs in maintaining structure. But at the same time we wouldn't have heard that he wouldn't be able to do nothing of that because he demonstrated that he was able to plan things out. Like, you know, all the plans for when he would leave the clinic, there he demonstrated some capacity to think ahead of different scenarios and plan out the steps to do what he wanted to do. So it's hard to tell.

Q. So you indicated he would benefit from some form of assistance. From your perspective, from an occupational therapist perspective, what would have he benefitted from when he's doing this transition when he gets back into the community?

A. Okay. Well, the first thing would be ... well the first thing, it's he would have benefitted from a functional assessment, a thorough assessment of his functioning in his environment. Within his environment. Because that's where, you know ... you can't really reproduce that in a clinical setting. The specific demands of the activities or obligations he has to meet, it has to be assessed ideally in the person's environment.

So that's what he would have benefitted from because that is what would allow the OT and the team help, essentially, to really figure out, you know, how in that setting ... how at home is, his OSI symptoms having an impact, how ... does it have any impact on different areas of his life including his relationship with his wife? There was also support, you know, for the family, for Mr. Desmond, and support for the couple that could have been given right from the start.

Even if it's just to start with to get some education and normalize their experience, the challenges that they're facing and that we can anticipate they'll still be facing in the months after of relearning to live together, to find a way to balance things out so that everybody feels that they have their place in the family, clarify, you know, each other's needs, roles, expectations.

(10:40)

Also to have ... if we're going back to just Mr. Desmond, to ... and to ... I was talking about the impact of his symptoms. Also on his performance and his activities we were able to assess with the MoCA and we will talk about that a little bit later.

Q. We'll talk about the MoCA later.

A. Yeah. So we were able to objectify. We were able to see ... to determine that there was some mild cognitive impairment. So the source of that, the severity of that, the extent of the contribution of that wasn't ... at that point we wanted ... you know, I can't tell you.

That's what to be ... that's what it is what to be continued when they're going to go back home to be assessed in how he was carrying out his activities, how also the feedback from his wife and the other people that see him function. His social functioning also. To be able to establish a more specific treatment plan.

Q. So the functional assessment that you're referring to that needed to take place. How soon, ideally, would that have happened after he left Ste. Anne's?

A. The sooner, the better. It wasn't an emergency but it was a priority for sure. It was a priority. Because ...

Q. Go ahead. Go ahead.

A. Well, because as it was a priority to answer questions about the extent of the cognitive impairment, the specificity and the nature of and the anticipated impact on activity ... participation. If the two were done the sooner, the better, because the two would give clearer answers. Like, for instance,

the assessment, the functional assessment, assessment of functional status of the performance of the person (inaudible) activities or obligations will also help contribute to clarify the diagnosis.

If you're seeing somebody when they're at home being completely disorganized this is precious data. This is data that needs to be analyzed, and together with the assessment from a neuropsychologist, the assessment from the other team members, all put together gives a much clearer idea of how (they'll learn?) treatment afterwards. So the sooner, the better.

Q. So who does a functional assessment? What mental health professional would do that?

A. An occupational therapist. Preferably an OT that is specializing in mental health and that has knowledge of trauma ... of military culture and trauma.

Q. Knowing what you know about Lionel Desmond, you talked about the importance of a functional assessment. You said the sooner, the better. What if in Lionel Desmond's case they said, It'll be about three months before we get around to a functional assessment?

A. Mm-hmm. Mm-hmm.

Q. Is that ideal?

A. Well, it's not ideal, but again at the same time, unless there were major concerns of safety or something like this it also will permit some time for the person to actually, you know, transition back home, get some time to kind of adjust and then be able to better see what maybe the challenges are.

So if you said two years later ... this is late but three months, if there is other people that are still, you know, offering support, even if it's not the full assessment that's done I mean the sooner, the better. But at least ... if there's ... you know, usually there would be more than one person as a team.

So if anything major comes up in terms of functioning and there is more concerns I guess that team or that person would interview to have ... to try to influence how quick the functional assessment can be done, if it can be done earlier.

Q. Did you recommend a functional assessment?

A. Yes, I did.

Q. And you recommended that in your discharge, the discharge summary?

A. Yes. Mm-hmm. Mm-hmm.

Q. Did you recommend a functional assessment in the case conference that was held by telephone prior to his discharge?

A. Pardon me?

Q. Did you recommend that as part of the case conference as well prior to Lionel Desmond's discharge?

A. Oh, yes, yes. Yes, usually, the document is sent as soon as possible. But the information is transferred through the teleconference before the person leaves ideally.

Q. So you talked about the importance in Lionel Desmond's case of a functional assessment, that it be done sooner rather than later. Is it concerning ... I'll tell you that a functional assessment was never done on Lionel Desmond. There was never an occupational therapist put in place for him at all. Is that somewhat concerning to you from what you understood when he's going to transition back into the community?

A. Yes, that's a concern but I ... it's a concern and at the same time it's a reality that sometimes resources might not be available. So what is going to come to compensate that? Was there a clinical care manager eventually involved? Was there anyone else who was able to have eyes and discuss, you know, daily managing, managing of daily life with Lionel Desmond? Was there also the neuropsych evaluation? Was that done?

So the important thing is that people ... that there's some people that are there that have eyes that can assess what's

going on and offer the support. You know, sometimes ... and there's been situations where I know if he was not able to be involved at some point in offering, like, a full followup. But it can be, for instance, a nurse clinician, a social worker, a psychologist that works and consults with, you know, an OT for their expertise and then can, you know, make recommendations for that person.

So it's a concern, but at the same time so I hope there would have been some (inaudible) and the impossibility to provide that (to the point?), I hope there would have been alternative means put in place or a plan to help in that regard as long, also, if the client accepts to be, you know, followed. Or accepts the recommendations that are (sent his way?).

Q. So on page 270, which is Exhibit 254. Ms. Beauchesne, this is your portion of the discharge report that was prepared by ...

A. Okay.

Q. The inter-disciplinary discharge summary. This is observations and recommendations as it relates to occupational therapy. You're familiar with this document I take it.

A. Mm-hmm. Mm-hmm.

Q. Almost at the time ... perhaps the ... start at the

top of the first line toward the end. He says ... you note:

> He was also seen in occupational therapy on a few occasions to discuss challenges and strategies for implementing and maintaining a healthy and satisfactory functioning routine during his stay and post-discharge.

So my question revolves around post-discharge. So there was some sort of anticipated continued followup with occupational therapy and strategy post-discharge?

A. Well, at the start it's addressed with the client as soon as they come in almost because, you know, that's ... yeah, it's a concern. As soon as they come in we start to address that reality of the transitioning back home with the clients. It's done collaboratively between members of the team and we encourage people to start already planning for how they want things to unfold when they go back home.

So in OT there is like a double mandate in the sense that, you know, there's the whole part of how the person is functioning on the unit while they're with us or are there any functional challenges there, what kind of support would be needed to assist in overcoming those challenges if there are any. There's a review of, you know, the functioning pre-

admission to give a better idea of how to prepare for what's to come at discharge.

So it's a discussion what's going to happen as soon as you presented this way, at least when I was doing it and when I would address it. And I know it's mentioned in that same document there.

(10:50)

There wasn't much possibility to go invest into this because what was predominant was, you know, issues related to his anger and managing his anxiety during sessions. So you know, when I'm talking about a functional assessment that portion is part of a functional assessment. It's one of the steps, you know, this having self-reporting for the client to evaluate whether the person thinks they have functional issues or how the person thinks their condition is impacting their activity ... participation.

And just that discussion in itself can bring a lot of anxiety to clients and resentment and bitterness and (inaudible).

Q. So indicated, I guess, another line down. I think you had sort of touched on it briefly. Same paragraph, probably a third line down, you say:

> Difficulties for Mr. Desmond to manage his anxiety or his anger were the issues mainly addressed, as it was difficult for him to discuss more in-depth daily functional challenges.

So was his anger sort of ... irritability and anxiety sort of getting in the way of even having a conversation about his day-to-day routine structure challenges?

A. Well, I think we can say sometimes getting in the way, but I think we can say just sometimes the object of the conversation, you know? Him expressing difficulties managing his emotions it was part of a discussion and when it's a discussion and it's not interfering with the discussion. It's just that it didn't go very far leading us ... I couldn't report in the end on very specific occupations or activities that were anticipated to be problematic.

I could have hypotheses but I ... so we weren't ... it didn't facilitate the process where it's meant to identify, okay, what areas will require performance testing? You know, where ... how should ... or are we on to the next step which is performance testing and which would be better to be done in an environment. But it wasn't necessarily interfering. It's just

that it was there.

But that's why I was saying earlier there was ... in itself there was a lot of clinical value. And, you know, people come to the clinic and they work on some elements and sometimes people eventually down the road of the recovery process will come back because they're at another stage and then we can work on something else.

So I don't see it as something that is negative all the way. It was something that was indicative of, okay, that's a priority for you to be able to continue on this road, in this process. This has to really be taken care of to help the person develop, like, self-efficacy and self-managing. Because there was, you know, insecurity. A sense of possibility of losing control when feeling overwhelmed by anxiety or finding himself angry and not knowing how to manage this in a constructive way.

Q. You noted under "Recommendations" ... we're going to get into the neuropsychological aspect momentarily. But in the second paragraph, the second line under "Recommendations", I'll just read in a line from the summary. You said: "A functional assessment by an occupational therapist is also strongly recommended in order to determine the client's actual functional capacities or limitations."

So my first question is, were there still avenues to explore about Lionel Desmond's functional capacities and his limitations when he was leaving the clinic?

A. Can you repeat that, please? Were there ...

Q. So when he's discharged from Ste. Anne's is further exploration still required in his functional capacities and his limitations?

A. Yes, absolutely, and that's what I was saying earlier. It's going to be really relevant to do so in his environment where he's going to be living in because the functional barriers are going to be then identified. They're going to be revealed depending on, you know, the demand of the environment, the demands with all the elements in the environment. You know, the environment in the house, the environment in the community.

For instance, just thinking of an example like demands related to getting himself to go to his followups, clinical followups. So for some people it means being able to drive for three hours to go see their psychologist, and for some people, well, it's almost across the street. So depending on the specific demands what were going to be issues, it depends. It has to be assessed. So yes, for sure, he had to be further assessed once discharged.

Q. So you're asking that an assessment be done for functional capacities and limitations and, again, who would be the person that would explore these while he's in the community?

A. That would be occu- ... well, yeah, it would be the role of an occupational therapist to do a functional evaluation and then to assess for performance, to do some performance testing to assess for the capacity for the person to meet the demands of different occupations.

Because that's what's going to lead ... not only to identify the barriers but that when identifying barriers to participation in activities for a reason is ultimately for the person to be able to do everything that they want to do in an independent fashion as much as possible. But when we're talking mental health we're talking, also, safety and we're talking also adequacy.

So how to get there. Once you've identify the barriers the bridge is to identify, so what's needed? You need to look at compensatory strategies. For instance, are we talking about cognitive impairment that is irreversible or reversible? Depending on where it's coming from, and that's with the neuropsychological assessment that we're hoping to get answers.

So this will orient altogether the type of strategies that

are going to be used depending on what we're trying to do and to overcome those barriers unless you have a person be as independent in their life as possible and having a satisfying and rich life. So for Lionel Desmond, again it was absolutely necessary to have ... to determine the most pertinent interventions be done, that the assessment be done in his environment when he returns home.

Q. So turning to cognitive functioning for a little bit.

A. Yes.

Q. You noted that you made some observations that caused you some, I won't say necessarily concerns, but it caused you sort of to question Lionel Desmond's cognitive capacity to some degree. What sort of observations did you make that sort of led you to, Maybe Lionel Desmond might have some cognitive deficits that need to be explored?

A. Okay. Well, the observations were from self-reported data in the sense that it's Lionel Desmond expressing, I think I have cognitive problems. And the source was the team questioning the same thing, having ... you know, putting out some hypotheses of, How come self-regulation and emotion, for instance, is so difficult? How come ... that is so difficult, is difficult. How come ... is the client expressing concerns?

There was, you know, report of head injury.

So all this together brought the team to question are there cognitive limitations first and, if so, what could they be attributed to? So I answered ... the psychiatrist described the MoCA testing done and I proceeded to do that.

Q. So I guess before ...

A. And ...

Q. Before we get into the results of MoCA testing. What is a MoCA ... Tell us what a MoCA test is.

A. So it's called the Montreal Cognitive Assessment. It's a screening test. It's a short screening test, 30 questions, quick to administer and it's really ... it aims to detect mild cognitive impairment. It's assessing cognitive functioning. That's what it is.

So it entails 30 questions, items, where different cognitive abilities are facilitated. Attention of (inaudible) functioning, language, memory. Attention I said. Visual/spatial skills. So cognitive function in different domains. It's a sensitive test that can ... yes.

(11:00)

Q. So you indicated it's sort of, it's a test that takes into various aspects of cognitive functioning which you said

involves attention, language, and memory?

A. Attention, language, memory, executive function, visual/spatial function, orientation to space, orientation to time. Capacity for abstract thinking. Yeah.

Q. And do you ...

A. So different tasks will solicitate different cognitive abilities.

Q. And do you recall what the results of this testing were?

A. I don't recall the specifics of it, but I do ... what I can affirm is that the results were indicated of mild cognitive impairment, mild cognitive dysfunction. And that would mean that the score was ... on 30, the score was below 26 and higher than 18. So it wasn't indicative ... there's no ... there's ranges that are suggested with the MoCA testing to grade the severity of the cognitive dysfunction. Even though it's not set in the terms of that there is more research to be done on that, but a score that's higher, if it's above 18, between 18 and 25 is a score that indicates mild cognitive impairment. It's not my expertise to analyze the cognitive functioning, per se, in terms of, like, the performance on the past, what it reveals of the brain function and everything. That would be

really the expertise of the neuropsychologist. And within the limits of my expertise and my role, it was to corroborate the hypothesis that there were some cognitive problems. And so the MoCA test, that I ... corroborated that there were mild cognitive impairment, that there were cognitive problems or changes. It couldn't say ... at that point, we could not answer the question why. We can't answer the question what's the source and we can answer partly the question of the severity because more testing needs to be done, more in-depth testing, with the neuropsychologist. And also ...

Q. Sorry, go ahead.

A. Yes?

Q. Go ahead.

A. No, I was just going to say, so we can have hypotheses, you know, because I've done in the past a MoCA test with a person who had no cognitive deficit when they come in, but that because of the medication side effects or because of just the anxiety of performance, they scored really not well, but, eventually, scored at re-test fine, so ...

Q. How many times ...

A. ... it's not an ...

Q. Do you recall how many times you administered the MoCA

test with Lionel Desmond?

A. Just once.

Q. Just once? So what is the logical next step? So you are requested and you administer a MoCA test and the results of the scores of the MoCA test say, Lionel Desmond, it appears as though he has mild cognitive dysfunction. What's the next step in the process? You mentioned a neuropsychologist?

A. Yeah, that would be the next step because ... I just want to say though, I just want to take one little step back to say with mild cognitive impairment we would see change. When we're talking about diagnosing mild cognitive impairment, okay, it's not efficient to just have a MoCA test. It's more comprehensive assessment than that and it tells also neuropsych testing, administration of psychometric testing, but also assessment of function. And across ... like, if I would've been in the community and I would've been mandated to do a functional evaluation, the steps would be where I would do performance assessment before doing an evaluation on the person carrying out their activities. And there are hints there, observations, that lead to think that there might be some deficits in the cognitive area. I would've then, you know, proceed to maybe do the MoCA.

At this point, with mild cognitive impairment, you don't

expect that they will have a significant impact or a major impact on social functioning or just occupational functioning. So, at the clinic, perhaps with the structure (inaudible) that helps you. We didn't see a person struggling with, you know, organizing themselves on a daily basis or nothing like that but, for sure, with mild cognitive impairment, it can have an impact in the sense that people might observe even people around the person and the person themselves, maybe they will see that they're not as efficient when they're doing things, when they're involving complex activities. Maybe they're making a bit more mistakes. Maybe they're doing things slower, but it doesn't interfere with independence. It would interfere maybe with performance quality or ... yeah. So ... where was I going with this?

Q. So I guess could there be an interplay between Lionel Desmond ... we know he had PTSD, struggles with emotional regulation. Things could trigger him fairly fast. He could get frustrated.

A. Yeah.

Q. Could there be a connection sort of between he has mild cognitive impairments that are taking things ... it takes him longer to do things that could, in turn, lead to

frustrations and trigger other diagnoses that he has? Are they connected?

A. They could all be connected for sure. They could all contribute. They could all contribute but the thing is is we have to rule out, it has to be ruled out, that ... or it has to be clarified, I prefer to say it this way, what the mild cognitive impairment is stemming from because anxiety ... because symptoms of depression, symptoms of PTSD, can also translate into cognitive difficulties. It can also translate into mood swings, irritability. It could also impact judgement, to some degree. So there are similarities there and so it's hard to really define what's responsible for what but, for sure, there could be both and they could ... yeah.

Q. Did Ste. Anne's have the capacity to do a neuropsychological assessment?

A. No, not at the time. We didn't have a neuropsychologist available so we weren't able to do the testing.

Q. And I understand it was one of your recommendations that when he leaves Ste. Anne's and returned to his community, that one of those assessments be done as well?

A. Yeah.

Q. Are you able to comment on whether ... and, at this stage, it's fair to say, you had indicated that you can't tell exactly what was the source and cause of mild cognitive dysfunctioning. That was going to be tested at a later time. But could mild cognitive dysfunction interfere with the effectiveness of various treatments for, say, depression, anxiety, PTSD? Are you able to say that or comment?

A. Could it interfere with the treatment? It could interfere with the treatment. To what extent, I don't want to go too much in-depth but I would say, yes, it could interfere with treatment. For instance, if a person has ... like, even just concretely, if a person has difficulty organizing themselves and there is more forgetfulness, they're more easily distracted, maybe they'll miss appointments, maybe they're less organized in their routine. It won't be catastrophic but it could have an impact. It can have an impact on maybe the person, how quick they going to integrate what ... they have a therapeutic (French term) ... how quick they're going to integrate the notions that are taught to them, the strategies that are taught to them. Maybe it will make it harder to translate those into specific behaviours on a daily basis. So that's where the OT can help offer support also. OT and other

types of professionals, at that point, can offer support.

So, yes, it can have some impact for sure but, again, the extent hard to say. And is it stemming from ... say if it's stemming from a head injury, if it's stemming ... is it the result of post-concussive symptoms, then that would be addressed. You know, the interventions would be tailored according to the source and the nature of the OSI. Is it just the review of medication that can make, you know, it reversible, you know ...

(11:10)

Q. Did you make any ...

A. It's going to be a (dynamic?) process.

Q. Did you make any observations about his attention or ability to focus?

A. Well, it was something I remember that was discussed. I think his attention and his ability to focus, one of the things that interfered for sure is how he would get overwhelmed with his emotions and how that would distract him. So, for sure, I would ... I feel comfortable actually relating that to that component. And then if there were attention deficits, per se, from another nature, that could interfere also with his attention and his ability to focus. So at the same time, there

were fluctuation and we saw a person be able to sometimes, in some circumstances, focus and be there and be present. And so in groups, he participated well, he participated actively. He was able to, you know, follow the conversation of the discussion and contribute to it and ... yeah. So ...

Q. Did you notice any sort of deficits or struggles with his memory?

A. I don't remember. I remember the team reporting that Mr. Desmond was reporting difficulties with memory. I think I remember that he, at some point, probably missed an appointment, but, like, I don't remember that it would be a major problem that he was forgetting things, like forgetting things, for instance, to go take his meds when it was time or forgetting to come to appointments in general. No. It's most mostly more from a ... like I said before to the data, Mr. Desmond, himself, mentioning that he was having difficulties with memory, and the team, you know, talking about that that led to eventually decide to also ... (for?) the psychiatrist to ask for the MoCA and for the team to say, Yeah, let's go ahead with this and it's going to support our recommendation for a neuropsych (inaudible) have the result that indicate there is cognitive problems.

Q. You noted in your recommendations, you talked about

Lionel Desmond has sort of multiple roles. He has the role of spouse, father, worker, friend. And, in particular, I want to ask you a little bit about that. If we could turn to page 270, the very last paragraph under "Recommendations" and the last three lines. I'll just read it there because I'm going to ask you a few questions about it. You say: "An assessment of the functional capacities will make it possible to identify the most appropriate level of support and strategies to be given to Mr. Desmond in order to help maximize his participation in carrying out obligations related to his different occupational roles (father, spouse, worker, friend)."

I guess in non-occupational therapist language, what do you mean, in straight sort of terms? What do you mean by that?

A. Yeah. As you were reading, I'm thinking, this is really occupational therapist language. If you're talking to a social worker, you'll hear social roles. But, really, what it means is, you know, the person ... well, the roles are very much life in the present because there was a loss of the military role and there's, you know, the civilian life and the roles of a father and see what the person, Okay. What roles are present in your life right now? What's your satisfaction in carrying out obligations and responsibilities to meet the expectations of

those roles? And also to look at future roles. What would you like to add in your life now that you've lost the role of military? What else would be significant?

So, you know, it's the whole process to work on roles and to find out the person ... to define how to carry out those roles in a meaningful way. Like, for instance, how to be a father to your daughter for Mr. Desmond. I want to be a better father. Like that's operational is that. Let's see ... what are the barriers that you consider that are there that can't ... that prevent you from being the father that you want to be? If you were the father that you wanted to be, what would that look like? And then engage the person and committed action. Engage the person in making choices to move toward that, you know. And the same with all the other roles.

If a person, eventually, it's determined that they want to, you know, go back and work, well, okay, so we're going to start slowly and see what would that look like for you? And then take into consideration any limitations that are going to identify either some that are ... that will have to envision compensatory strategies to overcome but are there some that you're going to work more as ... in a skills development perspective. So that's pretty much what it means. Carrying out obligations.

Obligations but, also, what does the person want to do? You're going to find that there's going to be a lot of work around values clarification, especially, you know, with the coming out of the complex of military. It's going to have an impact on the person having to review, kind of, what their values are and what does that mean in their life? What kind of ... redefining their life and goals and their occupational goals. Just goals in general.

Q. So when Lionel Desmond leaves the clinic on August 15th and you do make a recommendation, so was there still sort of further exploration of the struggles he had in his role as father, spouse, employee, friend? Were there still areas that needed to be worked on with Lionel Desmond in those different dynamics?

A. Oh yes, oh yes. The work was just ... you know, the work was just beginning, in a way. He ... it was going to be a long process with anticipated, you know, success along the way to continue to run ... be engaged and go through the process. But, for sure, because just, again, going back to live with his family when it was not the case for a long period of time, adjusting to that, there was support, yeah, for him, but also for, like I said before for his family to see how to make things

work and how to have everyone feel comfortable with their position, and what does it mean to be a couple? How is that going to work for us and do we have a vision that's common on how we want to be a couple? How do we want to, you know, be parents? How we can have a vision ... develop a common vision, of how we want to be parents to our daughter. There's so many areas, and that's why collaborative work with other professionals ideally is ideal, like, with a social worker, for instance, she can go more in-depth with the family dynamics. But, again, like, for the occupational therapist who is working with the client, maybe help the family translate into concrete means what they would discuss in social work with their social worker, right? So, for sure, it was something that needed to be (inaudible).

Q. So when Lionel Desmond returned to the community, would he have benefitted from having the occupational therapist perhaps work with the social worker, (1) to define those barriers, and then (2) break down the barriers?

A. Yes. Yes, that would be great interdisciplinary work because ... and very useful for the clients to have a common understanding from all team members of what the issues are the family is facing and then to kind of ... I don't want to use the

word "dispatch", but to attribute to different professionals who's going to be working on what and make it very clear with the clients and their families, too, so that they're not too confused.

Q. And, in your opinion, is that something Lionel Desmond needed when he returned to the community?

A. In my opinion, I'm convinced Lionel Desmond and his wife and his family would've benefitted from that for sure, yeah.

Q. And speaking of his wife, Shanna Desmond, I understand that, you know, your recollection might not be perfect on this, but you had been present for a telephone call in the, I guess, weeks leading up to his eventual discharge ...

A. Yes.

(11:20)

Q. ... where a call was made. Kama Hamilton had made the call. If we could turn to page 266 of Exhibit 254. I'm just going to bring it up on the screen. This would be a report from Ms. Hamilton. So I'm mindful that you didn't prepare this report, but it does indicate that you were present for the telephone call, and it was documented as August 12th. What do you recall from the interaction between Lionel Desmond and

Shanna Desmond in the days before he was leaving the clinic? How did their discussion go?

A. Frankly, I have no real recollection. I don't remember being in the meeting but I know I was by now. I honestly don't, I have no souvenir of being there at all. I know why I would've been there, that I could talk about. I know that there were tensions between the couple. I know that there was insecurity on the part of Mr. Desmond, because it was not just in the meeting, but there was insecurity on his part and anticipation on how things were going to unfold. I know that he was reactive to not hearing from his wife a message that was reassuring to the extent he would've wanted it to be. He wanted to hear, There's no way I'm going to abandon you. There's no way. You know, things are going to be perfect. We're going to go through this together. That's what he wanted to hear. He didn't want to hear any condition, you know. It's going to work if. This I remember this general, like, that I was there, but I don't remember the meeting for some reason. I wasn't organizing it. I was there as support. I was there. I would be in a meeting like this, especially near the end, that near to the end when we would want ... that's a way to ... that's one of the ways that we involve families in our program. When we're close

to the discharge, we'll double-check and check through different means. We'll go explore like at this point on your part, on the family, Are there any preoccupations and can we give you any information here to make things run smoothly when your family member comes back from the hospital. So this is why we do that. And maybe to point out specific things on the teleconference or on the discharge summaries for the team to know if anything is revealed.

So I know, again, there was tension, but I don't recall specific reactions or specific interventions that I'd done or even that Kama has done. So it's kind of difficult to talk about that.

Q. So you indicated you do recall sort of a general sense of he needed ... is it fair to say, you recall perhaps that he needed some reassurances that his plan was going to go as he wished it to, which is move back in with his wife and daughter and have a happy marriage?

A. Yes. I think I remember some disappointment of maybe not being a witness of as much enthusiasm on the part of his wife that he would've liked, and as much reassurance on the part of his wife that he would've liked. I think ... I know there was hesitancy on her part. There was self-reservation going on,

you know. Like she wanted to be present, she wanted to ... she was ... you know, she was showing that she wanted to be present because she was participating, for instance, to a call like that. So there was willingness there to be supportive but, at the same time, there was some self-reservation because of her history of ongoing conflict. And I think that him witnessing that from her, or knowing that from her, was provoking a lot of anxiety. It was provoking probably some anger, you know, because I don't remember specifically the reaction, like I say, in the room or in the ... during the call, but I remember just, in general, the state he was in.

Q. So in terms of ... you get the sense that he has one idea in his mind what he wants things to be when he leaves. There's indications that his plan, as he likes ... would love to have it, is maybe not going to be the reality. You talk as well about the importance of a functional assessment to see Lionel Desmond in his community, see him in his environment, and then be able to figure out how you'd come up with a treatment plan.

A. Mm-hmm.

Q. Knowing that he was leaving, with the uncertainty surrounding his wife, did that add a level of urgency, in your opinion, to have such an assessment completed?

A. I would talk about priority again because, you know, the different scenarios have been already discussed, talked about with Kama, anticipated in case (inaudible) that you wanted because he was going to go ... like one thing that was sure that he was going to go and move in with his wife and daughter at her parents' house, it was the next step that he wanted to be reassured with that she would not give in to but that she would ... that's not the right word. But she would accept and consider is moving out of there together as a family, right? So that was where it was not ... she wasn't able to give him a firm answer on, that's why we knew there were kind of conditions - We'll see how it goes.

And just to mention, functional assessment, you know, it's a dynamic process. So it's something that would, you know, you go with the flow. It would be done throughout the different steps because it's a follow-up too. So there was functional assessment, there was treatment targets, intervention targets that are identified. But then, while working with the patient and their family ... (inaudible) the family, Mr. Desmond and his wife and their daughter, you know, real observations or observations and new elements that would come in the picture would also be then taken into consideration and lead to other

treatment planning elements.

So I would talk about priority again. Not urgency, but priority (in myself?).

Q. There's an example of, say, a veteran leaves Ste. Anne's. His wife and daughter are there to greet him with a hug and they're fully supportive, fully welcoming, want them back home. And then, I guess, there's Lionel Desmond's case that has a little bit of uncertainty. Shanna Desmond is going to take him back, but it's subject to conditions, and we know that this phone call didn't go well. From your perspective as an occupational therapist that focuses on psychosocial development and interventions, was there a sense of a little bit of there might be some instability in his environment after he leaves?

A. Well, there's elements of risk in terms of elements that were susceptible to interfere with things running as smoothly as we would want. But, at the same time, just as the person ... because it's not only Lionel Desmond's case. Many families anticipate the returning home of their loved one after treatment. They have their own, you know, expectations and their own perspective of how the person should be when they get out of treatment after residential. So just as the clients ... I mean, before they leave, like Mr. Desmond had, you know,

anxiety arising approaching the end, the family also experiences that most of the time. It's like, yes, when they leave and they go to treatment there's so much hope, et cetera, but once reality is getting back soon, they experience a lot of anxiety also.

So that's why it didn't stand out ... yes, there was a history of conflict and the results are different from other (client?) situations, but there was also a possibility that it went well because he was going to live with his wife and daughter in his wife's parents' place, so there were challenges there, but there were also elements of support there. There were ...

Q. Do you recall how this conversation ended?

A. No, but I know it did not end well but I don't remember.

Q. And Ms. Hamilton notes that it was ... do you remember shouting and swearing during the call? Do you have a recollection of that?

A. No.

Q. Ms. Hamilton notes, It ended up with shouting and swearing and Shanna Desmond hangs up.

(11:30)

Were you involved in any other sort of assessment of his plan to return home with her after that?

A. Not specifically. I was involved, I guess, at the moment, like just after the call. I guess I was still there and so I would have given support and we would have done like, a review of how things went and why this happened and so on, but that would've been done, mostly, with Kama Hamilton. And I'm not even sure that she had another phone call with Mr. Desmond's wife after that or ... I wasn't ... I don't think I was involved in any other phone call with them.

Q. Do you recall your sort of interactions with Lionel Desmond after that phone call, sort of immediately after the phone call, how he was?

A. No.

Q. If I could just have one moment.

A. Okay. Yes.

Q. I think that is all my questions. Thank you so much. Your Honour, I believe that will conclude the direct examination.

THE COURT: All right, thank you. Ms. Ward isn't here. Ms. Grant?

CROSS-EXAMINATION BY MS. GRANT

(11:32)

MS. GRANT: Good morning.

A. Hi.

Q. Hi. Can you see me and hear me okay?

A. Yes.

Q. Great.

A. And yourself? Yes? Okay.

Q. Good. My name is Melissa Grant and I'm representing the various federal entities in this matter, including Veterans Affairs and Canadian Armed Forces.

Just a couple of questions for you. Can you just talk briefly ... and I know you're in Quebec but, in your province, if you're not a veteran, how would you access an occupational therapist? Would that be through a provincial system?

A. Through the provincial system or through the private system. There is providers in the communities.

Q. Providers in communities. Like independent ...

A. Yeah, both. Independent ... yeah. So both ways.

Q. Okay.

A. Through the system or private, yeah.

Q. Okay, thank you.

A. You're welcome.

Q. In this particular situation, and you talked a little bit about this with my friend, Mr. Russell, there were challenges in this particular case because Ms. Desmond was not returning to his referring health care team. Correct?

A. Mm-hmm.

Q. And in this particular situation, Mr. Desmond did return to a rural setting.

A. Mm-hmm.

Q. Would you agree with me that not returning to that health care team and not having that referring health care team would maybe change the priorities of the recommendations? And I guess what I mean by that is if you're starting, essentially, from scratch, would it make sense, from your perspective, that maybe one of the primary things you would do is try to get a psychotherapist in place?

A. I just want to say that it's not really starting from scratch because there ... well, we were relying or we were thinking that all the communication would be done as thoroughly as possible in terms of, you know, what the client has experienced with us, all the recommendations upon discharge. But all this would be transmitted to anyone that would be

involved afterwards. So I'm not sure that a psychotherapist would be a priority over, for instance, a (very good?) follow-up with a social worker or a ... It would really depend ... it would need to be reassessed, to some degree, by the case manager with the treating team that's going to be working with the client to do a reassessment then and there. Okay, now you're back because maybe ... because sometimes the perspective of a client before he left and the perspective of a client once he's back in his community can change quickly. He can anticipate for weeks that he's going to go back home and it's going to be difficult and trans- ... but then once it can be very well, he can cope very well, and maybe the person that's going to benefit more, yes, from psychotherapy to be the priority treatment, but it can also be, Okay, let me just get back into my routine and have this work out for me and my family and take a break from psychotherapy and just, you know, build a foundation and adapt to that transition back home. And then continue on with psychotherapy.

So I can't comment that, for sure, it should've been, for instance, a psychotherapist that's prioritized, but I think it would've been beneficial that a psychotherapist be a priority like the other recommendations I recommend to continue, yeah,

for work.

Q. Thank you. And I guess what I heard in your answer is that what the client wants is of a sort of primary concern.

A. Yes, I was going to ... I had that in mind, too, and that too because ... exactly. We have to have that approach, I think, for it to be a success to ... you know, with the trust issues especially going through so many changes. Having to change teams. So I think it's very important to consider what the client and their family (insert?) also as to what their needs are, one step at a time, and that it be reassessed regularly, though.

Q. So, in this particular case, you'd agree that ... and my friend used some language earlier about, you know, whether something would be in Mr. Desmond's best interest or would it have been an optimal scenario that we also have to respect the fact that he made a certain decision to move back to his hometown.

A. Absolutely. That's hard sometimes for teams to come to terms with clients not adhering to what the team really thinks would be the optimal scenario but, at the same time, you know, that's part of the process. That's giving back some power to the person and, yeah, I think we have to respect that, unless

there is concerns, like, of an immediate or imminent risk for the safety of that person or of, you know, any other person around them. I think it's important that aspect. That's, you know, the basis of client-centered.

Q. Client-centered. And just on that last point that you said "unless there's an imminent risk". So I take it from that answer that your team and you, in particular, did not see an imminent risk of harm to self or others when Mr. Desmond left Ste. Anne.

A. No, we didn't. No, because if we did, he wouldn't have left Ste. Anne's or he would've left Ste. Anne and he would've gone to a psychiatric emergency or something like that. So, no. We saw a man that said he understood the implications of his decision to leave in a scenario that we didn't find was ideal but, at the same time, we had to give him the benefit of the doubt. We saw him organize himself. We saw him take his necessary steps and sometimes, also, you know, to let a person find out by themselves that it's worth it to review how they go about things. So there were ... because there was a team there following through with another team. That was what we were relying on. We, from our place, I agree, like I would have to say, it's hard to read what all the challenges that they're

going to face. You know, the team. Like, for instance, in New Brunswick, and coordinating so that continuity of care is done in Nova Scotia. Of course, we can have an idea, but we rely ... from the moment when we deal with the external team that was supposed to be the one that was going to be there, we relied that they're going to take it from there and do everything that they can to make sure that ... even though there's a move. And, again, so depending on how much collaboration the client is offering, yeah.

Q. Was this a unique experience, though, that a person was not returning back to their referring team? Is that unusual with patients who are admitted?

A. Yeah. It's not a common scenario. Not a common scenario. There's often changes in the scenario as initially determined and but usually it doesn't involve changing a treating team.

(11:40)

Q. Okay. And ...

A. Not ... nowhere, no.

Q. Just going back to the discussion about the identification of a potential mild cognitive defect.

A. Yes.

Q. In your view, when you dealt with Mr. Desmond, he could ... this wasn't a type of cognitive defect that, for example, a person couldn't distinguish between right and wrong or reality versus fiction.

A. No.

Q. So I guess I would ask it in a different way, that you didn't have any concerns that he was potentially delusional.

A. No, I didn't have any ... but that's not really ... that's more like psychological functioning. That would be really a question that a psychologist would be maybe best able to answer in a specific manner. But if we're talking about judgement, if we're talking about, you know, being able to recognize different elements of risk, I can't say it was a hundred percent, but I can't rate it. I can't say I had no concern because from the moment he's determined with a score that's indicative of mild cognitive impairment, so it brings a lot of question because ... and that's why we refer to a neuropsych eval. We want to answer, you know, all the questions. We want to know what is it that really we're dealing with but he's dealing with. But, no, there was no concern in terms of him not being able to evaluate risk at all, yeah.

Q. This process here that we're engaging in is, you know,

we're looking at something through the lens of hindsight and not necessarily, you know, knowing what would've happened. There was a lot of emphasis in your discussion with my friend about the neuropsychological assessment, about the functional assessment, to the degree where it appeared that there was some line being drawn between, if these things had happened, the tragedy wouldn't have happened. And can you comment on that? It seems to me not a straight line.

A. I would never feel comfortable making that link. There's way too many variables. I would never feel comfortable in affirming that had these been done ... and I don't even know. Like I know now because Mr. Russell mentioned that there was (inaudible) at all (inaudible) about the neuropsych, but I would never feel comfortable affirming that, had these been done, it would've prevented the unfortunate events that happened. No.

Q. Thank you. Those are my questions.

A. Thanks.

THE COURT: Mr. Anderson?

MR. ANDERSON: No questions, Your Honour, thank you.

THE COURT: Thank you. Mr. Macdonald?

MR. MACDONALD: No questions, Your Honour.

THE COURT: Ms. Miller?

CROSS-EXAMINATION BY MS. MILLER

(11:44)

MS. MILLER: Good morning, Ms. Beauchesne. My name is Tara Miller and I'm counsel representing the personal representative for the late Brenda Desmond, so Cpl. Desmond's mother, and I also share representation with respect to Cpl. Desmond's late daughter, Aaliyah Desmond.

A couple of questions for you this morning on the heels of the questions that you've had already. You had been asked earlier about how important it would be to have continuity of care when Cpl. Desmond returned to his home treating team in the community after his time at Ste. Anne's. And the word that you used, as I recorded it, is that that was essential for him to have that continuity of care. So I want to talk about that a little bit.

First, I want to look at the things that Ste. Anne's would've done to assist with the transition of care to ensure that continuity of care post-discharge. So like he spent his time there, obviously, in the stabilization unit and in the rehab phase, but when he is discharged, the things that I've identified, and you can supplement this, there's, in order for Ste. Anne's to transfer that information, you have the telephone

case conference with the referring agency, is that correct?

A. Well, the tel- ... well, the ...

Q. That's one of the things that's done. You have a telephone ...

A. That's one of the things that's ... yeah. It involves the presence ... all the people that are invited to that teleconference is everybody that's going to be involved in the continuity of care that's authorized, of course, by the client to be there. So the case manager from VAC and the other members who have been determined to be the ones that will be continuing the care ... the treatment.

Q. Okay. So, in this case, we know that that case conference took place on August the 9th.

A. Mm-hmm.

Q. And I think you said that the people who are in that call have to be authorized by the client. So we understand that the referring agency, OSI New Brunswick, psychologist, Dr. Murgatroyd was present. We also understand that Cpl. Desmond's case manager from Veterans Affairs was present. So I take from that that Cpl. Desmond would've authorized both of those individuals to be there?

A. I don't have information that he did not authorize

anyone to be there. I think I would remember that but I can't affirm. I don't remember ... I don't have it in my notes who was there, who was present, maybe you do, so I can't affirm for sure, but for sure I can say that they would've been invited.

Q. Okay. What happens ...

A. So I can't confirm (inaudible - audio).

Q. What happens in a situation where the client does not authorize the attendance of various necessary entities to ensure the continuity of care back into the community? There's no suggestion, by the way, that that happened here, but I'm curious, in terms of from a process from Ste. Anne's, what happens when the client does not authorize that?

A. Frankly, it doesn't really happen because it's so important for us, continuity of care, that right from the beginning, there's much emphasis placed there. It's more of a formality when we revalidate with the client their concerns for the participation of those people to be there, that certain people to be there. But it could happen, for instance, in a case where, I don't know, a person has been working with a psychologist in a community that's not part of the OSI clinic and, but with time, the person with us, our team and with the team in external, come to realize, maybe it wasn't the best fit

and maybe I'm looking ... wanting to work with another psychologist and somebody else (when I get?) ... At that point, it could happen that a person would say, You know what, (inaudible) that person comes on the call.

Q. Okay, fair enough. Thank you for that. So you were a part of that case conference call and, as I understood your evidence, you would have specifically shared in that call that there was a need for the functional assessment and the neuropsychological assessment. Is that correct?

A. I don't have a note that shows that I was present there, but I would've been present there because, usually, that's what it is. Usually ... that's my function, I would've been present.

Q. Okay. And did I understand ...

A. And it is by the recommendation that I would've communicated the ones ... the same that were in the (inaudible).

Q. Okay. So the telephone case conference with the referring agency and the Veterans Affairs case manager, that was the first thing, I guess, that Ste. Anne's does to assist with the transition of care to ensure continuity of care.

The second thing that appears apparent is the discharge report that is prepared by the interdisciplinary team.

A. Mm-hmm.

Q. And so I want to ask you a few questions about that. The report itself, which is found ... and we don't need to go to it, but it's in Exhibit 254 and found at page 268. We know that it was prepared on August the 17th, 2016. From your perspective, who gets this report? Who is the intended recipient?

A. (Inaudible).

Q. Who is the intended recipient of any veteran's discharge report?

A. Okay. Again, our goal is to transmit or share this information with all the people that are involved in the treatment. So we would ask at the teleconference or via email at some other point, who wants to get it. We would validate the concept of the client authorizing us to share. And we would also give a copy to the client himself of the ... or send a copy to the client himself of the discharge summary.

(11:50)

Q. Okay. So there's a couple of things I heard there. The report, the discharge report, would go to those who will be involved in the care moving forward, including the referral agency.

A. Yes.

Q. And does that also ... that would include the Veterans Affairs case manager.

A. Yes, yes, also includes ... yeah, I didn't mention that one, yes.

Q. And it would also be ...

A. Always.

Q. A copy of this report is also given to the client themself?

A. Yes, yes.

Q. Okay. And was that the case in August of 2016? That's always been the process, that the discharge report is given ...

A. Yeah, that's the process. The person is informed that they will be receiving that ... the copy because it's also ... it's a tool also for the client, you know. It's a memory aide to some degree to go back to and remember all the recommendations that were given to him by the different professionals.

There is also, during the teleconference, an invitation to anyone who has any questions about the upcoming documents to call us back to clarify anything, to let us know if they

eventually want to access more documents, how to do so. So yeah. And I just want to say also, the teleconference was ... I understand the way you're bringing it and you're saying it's the first, like, action we're going to be sharing information, but, systematically, we're going to do that, but in a case-by-case, we're also going to be calling external team, if need ... if judged pertinent to do so at different moments during this date.

So, for instance, if we have in mind a recommendation that we find should, you know, be put to the attention of the case manager because we think there might be some challenge in finding the providers or anything like this. Sometimes it could also be that we called before or that we just called to inquire are ... would there be any difficulty or challenges and should we send in a recommendation earlier on in the process.

Q. Do you know, Ms. Beauchesne, whether or not any calls were made to any external team during Cpl. Desmond's stay?

A. I don't know. I can't tell you. But I think there might have with Kama Hamilton but I can't confirm.

Q. Okay. All right. So there's those sort of three things. There's calls that can be made on a case-by-case basis while the veteran is within the treatment program, there's the telephone case conference with the referring agency, and then

there's the discharge report. When the discharge report is sent out ... and, in this case, we know that although it was prepared on August the 17th, it was not actually sent out to the referring agency until October the 7th.

A. Mm-hmm.

Q. But when it is sent out, what is included with the discharge report? What is to be ... are there any additional documents that are to be shared at that point with the external team to assist with the transition of care?

A. Yes. There is also the psychiatry report, the medical discharge summary, but the client would receive only a copy of the interdisciplinary discharge summary.

Q. Okay.

A. The other two members would receive a copy of the ...

Q. Okay. So the ...

A. ... summary.

Q. The other professional team members, I guess - not the client themselves - would expect to receive the ...

A. Yeah, client case manager.

Q. Yeah, would ...

A. The case manager also.

Q. The case manager included, would expect to receive the

discharge report with the GP closing note?

A. GP closing note and also the transferring ... the psychiatrist's notes transferring from the residential ... the stabilization to the residential program. But, at this point, because it's been a while back and our process has been a little fine-tuned still, we are still revising it to make it even better now, so I'm not sure exactly where we were at at that point, yeah.

Q. Because we've reviewed ...

A. But I think a list of medication also.

Q. We've reviewed evidence previously where it appears that when the discharge summary was sent to the referring agency, it did not include any of the psychiatrist's material. It simply included the discharge report and the GP discharge. So do you have an understanding as to when the process for including documents would've changed?

A. No, I can't specifically ... I can't answer that specifically.

Q. Okay. And is there any way of recording that Cpl. Desmond would have received a copy of this discharge report because we have no ... there's been no evidence led to date that he ever received a copy of the report.

A. Okay. I guess we could have proof that it was sent ... if they go to archives of our hospital, we could see whether it was sent, but that it was received, I'm not sure how they do ... I'm not sure of their process, how they validate that the person actually received the document or no.

Q. Okay. But your evidence is that from a process perspective, the individual client should have received, or been sent, a copy of that report.

A. Yes.

Q. Okay. And ...

A. They have to even sign a consent for that.

Q. They sign a consent to receive it?

A. Yeah.

Q. Okay. And there's a ...

A. Near the end when they're releasing, they revalidate consent to, you know, allow sending documents to who, including themselves.

Q. Okay. And there would be a record of those consents at Ste. Anne's?

A. There should be, yes.

Q. So we now we're at a point where the veteran has been discharged, and my question is what, if any, role does Ste.

Anne's have in ensuring the transfer of care, in following up to ensure the transfer of care is happening, because that's so essential for success when the client returns to the community.

A. Mm-hmm. Well, there's no specific steps or plan done after discharge except finalizing the preparation of the discharge summary, if it's not already finalized, and sending it out, that process. But apart from that, it's really, from the point where the person is discharged, the preparation has been done, and we're relying that it's been handed over to the external team. So we're going to go ... if I go (inaudible), we're going to go and accompany sometimes a client to, in some sense, the airport, but ... and sometimes maybe we're going to call the person to find out if they arrived home. But apart from that, when the person leaves, it's very clear, and it's very clear from the start, that when they leave, they are not our client anymore, but we do everything we can with them the whole time they're with us to prepare that transitioning so that as soon as they walk out of the clinic, they become "client change" under the care of their external community of care. And sometimes we've arranged ... but I don't have ... I don't think it was the case with Mr. Desmond, but sometimes we, in our discharge planning, we've arranged to collaborate with the

external team, for instance, who have a clinical care manager welcome the client at their house or be there (inaudible) so there is sort of all the planning and the schedule. So the person usually leaves with a plan that, you know, sets them up for what's to come and to ensure that they'll commit to that plan.

Q. Okay. So in this case we know with Cpl. Desmond ... and you've indicated you knew that ... Ste. Anne's knew he was not returning to an external team. He did not have a team in the community. So your answer to my friend, Ms. Grant's question, she asked you if that was unique and you said it wasn't common that someone would be discharged back into community without a team. And, in that situation, is there an enhanced role, or do you feel there could be an enhanced role, for Ste. Anne's to play after the veteran's been discharged back into community with no external team that you're aware of before he leaves.

A. Well, actually, when he's discharged from our ... the external team remains external. The predetermined external team that was determined even before admission remains the team that's taking over when he leaves. So maybe the role ... like, in Mr. Desmond's case, they weren't going to offer ... or he

wasn't going to have follow-ups with them because he was deciding not to because he was moving but they were still the designated external team having to take over and continue to take the measures for the transfer of care to the other province.

Q. Okay. So, if I can summarize that, even in a situation like this with Cpl. Desmond when he's leaving to go back into a new community where you know there's no team of professionals there, Ste. Anne's is relying on the external team comprised of the Veterans Affairs case manager and perhaps the referring team - in this case, we knew it was OSI New Brunwick - to take your recommendations and that they have the responsibility for moving it forward. There is no further role or responsibility for Ste. Anne's.

(12:00)

A. No, but our role is really ... you know, our role is to really make it clear any concern that we have, any barrier that we have, that we have in mind, our role is really to care, you know, the most pertinent information for them to be able to work efficiently through our process. Because it's them and their community that know more, with the case manager also, what are alternatives ...

Q. Okay.

A. ... that can be (inaudible) and put (inaudible).

Q. Do you ... you had said earlier that certainly you tell the external team that they can call if they need further information. Do you recall or do you know if anyone ever called from any external team, being Veterans Affairs or in the community, Cpl. Desmond was returning to or from OSI Clinic? Did anybody ever call back to Ste. Anne's looking for further information that you're aware of?

A. I don't know.

Q. Okay.

A. I am not aware of (inaudible). But, you know, I would ... I wouldn't think, that it's highly probable that when we're encouraging external team and it's systematic when we always invite people and we always make it clear please don't hesitate - with the clients too - please don't hesitate to call back for any concern.

And in that context for Mr. Desmond, I'm sure ... sure, it's highly probable that we would have said to the external team and please transmit the message to the next team, that they can also call back even if, you know, they weren't involved during his time with us.

Q. Okay. I want to move now to ask you some questions about the recommendation for the neuropsych assessment, Ms. Beauchesne. So my understanding of your evidence, and I just ... I'm going to try to summarize it and you can say I'm correct or not correct.

So my understanding is the ... what led to the recommendation for the neuropsych assessment was Cpl. Desmond's self-reporting of certain things coupled with the Ste. Anne's team observation of some of these same issues. Was it a combination of those two things, am I correct in understanding that, that led to the recommendation for the MoCA assessment?

A. Yes, that led to the MoCA assessment.

Q. Okay.

A. The decision to make a ... yeah, to assess.

Q. Okay. And do you have a recall of what the self-reports that Lionel Desmond was expressing?

A. Not specifically, but focus on memory, see I remember focus ... I believe it focussed on (inaudible), like attention challenges and the need to do things that were discussed.

Q. Okay.

A. But not specifically ... like not in a specific situations on the unit where there was a mistake that would

happen or there was a situation where that was like of major concern. So yes, there was this. And also when there was a report of head injuries and the elements of personalty that were assessed and (inaudible) some elements (inaudible) were identified. So it's all these things together that brought most of us to, I think, (inaudible).

Q. Okay. And did you ... did I hear you say that a psychiatrist actually had to make a prescription for the MoCA to be administered?

A. Not prescription officially. He probably wrote it in his notes, but it's something that we could discuss just in a group ... in our group meeting and (inaudible) said, Okay, we'll do this, you know.

Q. Okay, so it didn't need a psychiatrist's recommendation to action the MoCA?

A. No.

Q. Okay.

A. No.

Q. When did you administer the MoCA test assessment?

A. I don't remember. Is it in my discharge summary? No, I don't have a date, sorry.

Q. Okay.

A. I can't help you with a date.

Q. And you talked about it being scored out of 30 and anything between 18 and 26 indicated a suggestion of mild cognitive dysfunction or impairments?

A. Yes.

Q. Okay. And where are the results from the MoCA testing, the actual test results?

A. I don't have the actual test result. I don't report on the performance on the specific performance on each subscale of the test. If it was done by, you know, a psychologist he would use a MoCA, they would probably do that. For me, with (inaudible) my expertise it was really to use the test to corroborate and give an answer to the question. I (inaudible) of mild cognitive ... I (inaudible) of cognitive impairment.

Q. Okay. So there would be test results, though, from the actual administration of that MoCA? I mean, my understanding is there's a visual test where you have to draw a clock?

A. Yeah, but I wouldn't normally include this is in the file.

Q. Okay.

A. It's ... yeah, no.

Q. Okay. So moving forward from that. Once the test results showed an indication of mild cognitive dysfunction, if I understand it that mild cognitive dysfunction or impairment can actually be a result of a number of things. It could be a head injury. It could be ...

A. Yeah.

Q. ... symptoms of major depressive disorder and/or PTSD. Or it could be in relation to a neurological disease, such as Parkinson's or Alzheimer's. It could be any or all of those things.

A. It could be, yeah.

Q. Yeah, okay.

A. Any or all. It could be the result of anxiety to the point where the person stopped right in the middle of it and it wasn't concluded. It could be the result of medication and all the things that you mentioned.

Q. Okay. And the only way to tease out what actually is causing the cognitive dysfunction or impairment is to have the neuropsych testing completed?

A. There could also be other things done when we're looking into assessing cognitive dysfunction. There could be brain imaging also alongside with neurological assessment and

functional assessment, you know. Assessing performance and updating data, pointing out to incapacities, but again that wouldn't necessarily tell the source.

Q. Okay. But in Cpl. Desmond's case, all that was recommended was a neuropsych assessment. And the results of that were going to be instrumental in helping to narrow the diagnosis which would then inform treatment down the road. Is that a fair summary?

A. Exactly. Because that's the main goal is for having informed decision for treatments, yes.

Q. Okay. My last series of questions, Ms. Beauchesne, relate ... you know, you had recommended this functional assessment in addition to the neuropsych assessment and you talked about that earlier with my friend Mr. Russell. In the discharge report you talked about needing that assessment to be able to, I guess, help Cpl. Desmond carry out his obligations in his occupational roles as a spouse, as a father, et cetera.

A. Yeah.

Q. One of the things I wanted to ask you about in terms of his role of a spouse. You noted that there was ... you knew there was tension between the couple ...

A. Yes.

Q. ... and we know from the progress note that Ms. Hamilton wrote, which is at ... it's in Exhibit 254 just for the record, page 266, this is the progress note based on a meeting on August the 12th and the phone call with Shanna Desmond, and you were at that. And I appreciate you don't have a recall of that, but at page 2 of that note, which is page 267, first paragraph: "Writer pointed out that this is a new starting point for them and can help to rebuild their relationship but suggested that that they would benefit from a couples therapist to help coach them through this process."

A. Mm-hmm.

Q. Do you recall the recommendation for a couples therapist being made in that call?

A. No, I don't recall. I don't ... like I said, (inaudible) disturbing to me, but I really have no souvenir that ... of being there present in that meeting.

Q. Okay. Is that recommending couples therapy or a couples therapist, is that something that would fall under your purview as an occupational therapist looking to help someone carry out their obligations in their occupational role as a spouse?

A. Well, yeah, I do believe there's collaborative work

done by, you know, various professionals. And usually when we have professionals that are more trained, that have an expertise in couple therapies is social workers.

Q. Okay.

A. At the same time, in occupational therapy you can offer alongside that a lot of support for the family just normalizing their experience as a couple going through all these challenges that helping and promoting a healthy lifestyle, healthy routine, to take care of the mental health of a ... not caregiver, but as a family member supporting the person (inaudible) and Mr. Desmond in this case. Helping them with applying and fine-tuning maybe conflict resolution strategies that they've discussed with their couples therapist or just teaching them about some of those communication skills, et cetera, et cetera.

(12:10)

Q. So it sounds like from your perspective, that would have been a valuable tool for both Cpl. Desmond and his wife as he left Ste. Anne's and went back to his community?

A. It would have been a valuable tool to have some support as a couple for sure.

Q. Okay.

A. Whether it's OT, social work or another person.

Q. And you had recommended a functional assessment to sort of tease out these things to help him carry out obligations in his occupational roles. But is it fair to say that the functional assessment did not need to take place before couples therapy could be recommended and/or implemented?

A. Oh yes, I would say that for sure.

Q. Okay. Right.

A. Anything that can done the sooner the better. Because anyways ... the team with the client and their family will realize how interventions are meeting their needs or not or partially with interventions being done. So, at some point, they could have started with what was available, a functional assessment could be done but there was support that was being possible to be had by even if ... oh, that's ... the peer, even peer social support. It could ... you know what I mean?

Even if it's a couples therapy that's started but he didn't ... like after a month and a half the couple therapist realized with the family, with the couple, we're not going that far, or maybe we should prioritize for now psychotherapy sessions just for Mr. Desmond and maybe on your end also for his spouse to go and do some work.

And maybe then the OT can come in and work with the social worker together or one or the other. Because it's a dynamic process. It's not set in stone, but I would say for sure any form of support to start with to be able to rapidly to assess how things are going roughly, like, to give ballpark picture of how things are going or (warranting?) treatment ... or warranting further treatment.

And sometimes even if you're convinced that, you know, that the treatment plan should be assigned in a specific way it can be modified once a person gets home. Because that's their real life, there isn't less ... you know, people thought they were going to react with openness to couples therapy and then they realize it's too threatening and they're not ready for it and they have to learn to cope with the stigma first and then that can be done in another setting so ...

Q. Okay.

A. Yeah. The priority is that there is somebody there and that there is support.

Q. Okay. Thank you, Ms. Beauchesne.

A. Yeah.

Q. I appreciate your time.

A. You're welcome. Thank you.

JULIE BEAUCHESNE, Cross-Examination by Mr. Rodgers

THE COURT: Mr. Rodgers?

CROSS-EXAMINATION BY MR. RODGERS

(12:14)

MR. RODGERS: Thank you, Your Honour.

Ms. Beauchesne, thank you. I'm Adam Rodgers and the I'm the counsel to the personal representative of Cpl. Lionel Desmond. You've been very thorough and insightful so far and so I just have a few questions for you arising from what you've said so far already.

Ms. Beauchesne, first I just want to ask again how often it is or how many, if you could estimate, Afghanistan veterans you've had the opportunity to deal with in the course of your employment?

A. I can't give you a straight answer. I would say many along the years but I can't give you an estimate ... number. Sorry.

Q. Okay.

A. Many.

Q. Dozens? Hundreds? What would you ...

A. Well, at least dozens.

Q. Okay, thank you, that's what I presumed. I mean and

this would be all at the Ste. Anne's clinic where that experience would have taken place?

A. Yes.

Q. Yes. And fair to say of course, that that's still a small subset of the entire regiment and contingent of Canadian soldiers that actually served in Afghanistan? Would that be a fair statement?

A. Yes.

Q. Ms. Beauchesne, I can imagine listening to your testimony that in a world of, I suppose, infinite resources just about anyone might benefit in some way from a neuropsychological examination and a functional assessment. But my question for you is can you give us a sense of how often it was that you made this kind of recommendation for soldiers that you treated that were Afghanistan veterans?

A. I think it would be fair to say that quite often our team decides to refer for more testing because the people that come to our clinic often it's because something is not working out and they're not progressing like it would be anticipated they would in the external setting.

So oftentimes people that come to our clinic come with profiles that have elements of complexity and ... or that have

elements of complexity but that have not necessarily been identified. And the people coming into our setting with, you know, 24/7 observation/assessment allows us sometimes to be able to put a finger on more specific elements of complexity and then form hypotheses of what the source of those elements are and that would work ... that will guide them or recommendations.

So it's not rare that we recommend neuropsych evaluation to understand. Because the population that comes for treatment at our clinic we have that ... our consideration of the potential effective TBI, traumatic brain injury and, you know, all the symptoms related to their OSI, their depression sometimes, the cognitive problems, so it's often something that we find pertinent to address. Not in all cases, but it's not uncommon.

Q. One can imagine based on what you said before about how in the clinical setting of course you have a very structured environment and then when a person is released back to the general population in the world while those circumstances are much different, then a functional assessment would then take that difference into account.

So is that one of the reasons why you would frequently maybe recommend a functional assessment?

A. I'm not sure. Could you repeat that? I just want to

make sure I understood your ...

Q. Sure. Well, I guess maybe I'll back up a second. I combined the two assessments when I originally asked you the question about how often you would recommend them, so maybe we should break those down.

Is it both that ... would it be in both cases, neuropsychological and functional assessments, are those both frequently recommended?

A. They're both frequently recommended but they're not necessarily always recommended both of them for each client.

Q. All right.

A. Yeah.

Q. Okay, because based on what you said earlier about the distinction between a clinical setting and a real-life setting ...

A. Yes.

Q. ... and the distinctions from the functional side, one could certainly see that taking place.

And is that the reason why that would be frequently recommended or are there other reasons?

A. No, it's because ... it depends on pre-admission, the level of functioning pre-admission. So if ... it depends where

the functional issues, if there were any lie ... where they were lying before the people came to our clinic. Why were they referred to our clinic? Is it because of a dysregulated routine and the inability to have structure, is it that that was the main issue that prevented them from going to their appointments and benefitting from their treatment in the external or was it because there was a time to adjust medication and that that be done in a more ... in a place where there could be constant supervision to assess the impact of adjustment of medication. So it really would depend on the assessment of what is anticipated after discharge.

And also, for the people that can it is always encouraged after a period of time that people go back on weekends and go (out?) to therapy passes that go out in their home, they return home. Even some people that are out of province, sometimes they return home for a temporary "conge", a few days anyways, and go test themselves, so that too will be taken into account.

(12:20)

If they come back and they say, You know what, now with how I'm doing I feel like I'm really in control, on top of things and I don't feel that stress from my day is going to be a problem then there won't necessarily be a recommendation to go

... you have a whole functional evaluation.

But, at the same time, it could be then a recommendation for a followup in occupational therapy for like for more specific element element. So it really depends. It really depends, but yes, a lot of our clients coming in to the setting have experienced before coming in difficulty in establishing structure in their life, establishing a routine that was giving them balance or satisfaction.

Q. And then in a different way, but perhaps as frequent, I'll ask you, is the neuropsychological exam, for those that have PTSD, brain injuries or some complex presentation of brain functional issues, so is that an infrequent or a frequent recommendation on the neuropsychological examination?

A. I think the answer I'm most comfortable with is that every time the team judges it to be pertinent to recommend it we never hesitate.

We don't abstain from making a referral even though there could be the possibility that the resource we have there, because we find it important to make it clear that we find it pertinent to do. So it really depends on the person and on the profile that they're presenting. So unfrequent, frequent, it's ... I don't know it's ...

Q. Well, no, thank you, Ms. Beauchesne. I just ... it seems like it might flow from those responses that it wouldn't be unusual then for care teams or Veterans Affairs to be receiving those recommendations from Ste. Anne's.

A. Mm-hmm. That's fair to say.

Q. I was interested to see your description of the occupational roles and the roles being father, husband, friend, potentially worker, but those other three roles in particular. Essentially, that for some veterans will become their new job, their new occupation. Is that what you're trying to say by putting it that way?

A. By giving examples of the different roles?

Q. Yes.

A. Well, actually it's just I guess because I was using occupational therapy vocabulary like Mr. Russell was saying in talking about occupational role, but just I guess to give examples of what I was talking about, so it could be just roles or social roles. But yes, for some time, of course the person is released from the Forces and they're not yet that and yet re-engaged in kind of vocational activity, whether it's paid or not, they'll be focussing on the roles that are present. The roles that are present in their lives and that they can start

engaging and then making more satisfying, you know, and contributing to feel more satisfied.

Q. Is that something you talk about in group therapy or in therapy at all, that transition from being a soldier and this is your occupation, to now you're transitioning into a different kind of occupation? And what can you tell us about those kind of discussions? How difficult it might be for soldiers to accept that transition.

A. Very, very difficult. Very difficult to accept. It's their whole occupational identity. It's their whole conception of themselves just, you know, the fact of being not a military but being a civilian is very confronting. And it's confronting because it's a reminder of them not having the same potential anymore because that's what it's about, the release, because you don't have the potential to be doing your role in the Forces.

So it's very ... it's a lot of loss, it's a lot of grieving.

So, yes, the challenges related to transitioning are addressed in group therapy, they're addressed in psychotherapy, they're addressed in occupational therapy, in social work, in different manners but they are constantly being addressed. They're addressed between the clients themselves on the unit. They're

addressed at the peer support worker that comes on the unit and talks about his experience and, you know, shares with the clients.

And also not always talking about just veterans' release but there's also ... we also have clients that are still in the Forces and are anticipating that that might happen to them. It's not always the case, but most of them when they're at that point most of them are not going to be returning to work; they're waiting for a liberation date or something. So it's a constant topic that is addressed to help them with that transition.

Q. And then, of course, then it flows from that then that the functional assessment would particularize those transitional challenges for each individual and help inform the treatment that would result from or that would be needed by each individual. Would that be fair to say?

A. Yeah, well, because the functional assessment idea would be carried out by a professional that has an understanding of the context the person is in and they understand the specifics of that complex and will be more (French term) - more aware of how it impacts the challenges. That could be ... that could look similar, for instance, with somebody that's retired

in the civilian world, okay, there's going to be similarities in the challenge where, you know, there's a loss of a worker role that was very significant.

But if you're going in there and you're working with a veteran you have to understand the context, again, how it's going to influence his experience and his family's experience. Because also the families are very much affected by the transition process so that's super important to have them involved in the process.

And record social integration for the individual but also for the whole family. Help the family deal with the stigma associated with the mental health condition and all the consequences.

Q. Thank you, Ms. Beauchesne, that's very helpful, those responses and that insight, and I appreciate that. So those are all the questions I have for you.

A. Okay. Thank you.

THE COURT: Thank you, Mr. Rodgers. Mr. MacKenzie?

MR. MACKENZIE: No questions, Your Honour.

THE COURT: Thank you. Ms. MacGregor?

MS. MACGREGOR: No questions, Your Honour. Thank you.

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

have any further questions?

MR. RUSSELL: Nothing else, Your Honour.

EXAMINATION BY THE COURT

(12:28)

THE COURT: Okay. I just have a couple of questions.

The first question relates to a clinical care manager and I know that from the discharge report there was reference to a clinical care manager and I would be curious to know what a clinical care manager would look like. Like, what would you expect that individual's background or skillset to be in relation to a person such as Cpl. Lionel Desmond?

A. Well, a clinical care manager is a role that was developed by VAC and to work with veterans. And so, for sure, they ideally have specific skills and knowledge - the same that I was mentioning earlier, military competency and trauma-informed practice, integration of that.

They will have an understanding, they would be educated about all the specificity of the challenges that would be faced by families and veterans once they're released from the Forces or going through release, going through the transition.

A clinical care manager is given a mandate to provide a

service, to my knowledge, for a determined period of time which can be re-evaluated once that comes to terms. It can be different types of professionals can be in that role. It can be a psychoeducator, clinician nurse. It can be an occupational therapist that has a mandate of being a clinical care manager for a person for a determined period of time.

(12:30)

So that person will be identified to support the person, the individual, and their family also, in their daily lives. That person will also be there sometimes to implement recommendations to help a client and their family implement recommendations that were given by professionals. They can maybe work in collaboration with, for instance, psychologists to help the client do (French term) - to do exposure or to put an occupational exposure protocol in collaboration with the psychologist.

So they would be given a more specific mandate. Like, for instance, if we recommend a clinical case manager sometimes we won't be very specific because we just want ... you know, we think it would be beneficial for the transitioning. For instance, if a person was alone, they don't have much support, and they're going back in the community. I mean apart from

their treating team. We might offer that just for a couple weeks for that person to help adapt to a new situation.

But sometimes we will make specific recommendations as what we think the mandate of that clinical care manager should be and that's going to help the case manager determine which type of professional there will be carrying out that mandate.

Q. So the decision or the ... I'll call it the decision. The decision to direct a veteran to a particular case manager starts with the ... or clinical care manager ...

A. Clinical.

Q. ... starts with the case manager. Am I correct?

A. Well, it's discussed with us and the case manager.

Q. That's what I mean, yes.

A. Yeah, exactly. So it's a decision that's been discussed and ... yes.

Q. And I take it that the determination of how the clinical care manager is going to assist the particular veteran, do they take guidance from the case manager? Is that ... or do they do their own assessment, their own judgment, together with whatever ... for instance, in this case there would be a discharge summary. Is it expected that the clinical care manager would incorporate all of that information and then

determine what assistance they're going to give to the particular veteran?

A. Well, it's a bit of both. I think they go in normally with elements that specify what their mandate is going to be, but at the same time they're professionals with their own background and expertise and I'm sure they can share observations and collaborate with the treating team, the rest of the members of the treating team, in recommendations for adjusting treatment or integrating other elements in the treatment, reflecting back some of the challenges with implementing, maybe, some of the recommendations so that maybe that could orient treatment and knowledge.

Maybe that feedback will bring ... I don't know, the other psychologists or the occupational therapists to reassess and reevaluate, you know, what a couple of the issues are with a person and then go back to the clinical case manager and discuss how to go about that.

So I think it's super-important that there is that collaboration all the time. I know it's not always easy when people are not working necessarily in the same physical place, a team that is provided in the community that the clinical care manager mandates. But I think it's essential that they

communicate all with each other and the client.

Q. Thank you.

A. You're welcome.

Q. I appreciate a comment that you had made earlier in relation to a question from Ms. Grant about not being able to draw a straight line between any particular recommendation and whether or not it was followed and the deaths that occurred on January the 3rd, 2017.

A. Yeah.

Q. So I'm going to ask you a question. I'm going to just give you some background that you may or may not have. So we know that Cpl. Desmond entered the clinic on May 30th and that he was discharged on August the 15th, 2016.

A. Mmm.

Q. And appreciate that there were some recommendations. So at the time that he left the clinic at that time you said that there was nothing to suggest that he was either homicidal or suicidal and if there had been at that stage there would have been another or a different course of action. Am I correct?

A. Yes, absolutely.

Q. Okay. Now we know that Cpl. Desmond returned to Nova Scotia and on October the 24th, 2016 that was just over ...

maybe two months, two weeks later after he left Ste. Anne's, he was at the emergency department at St. Martha's Regional Hospital where he saw Dr. Slayter, who is a psychiatrist, and the hospital record noted that he had been diagnosed with PTSD since September of 2011 and he currently ... he was not sleeping. He was having vivid dreams and nightmares. He was having night-sweats. He was angry. He was struggling with aggression. He had poor appetite. He felt overwhelmed. He had outbursts of aggression to objects. Outbursts are sudden. He had paranoid thoughts about his wife. He had conflict with his wife. He was isolating himself. He had a general distrust of all people. He was experiencing anxiety, depression. He had trouble adjusting after returning from the military. He's not sure how to live as a civilian.

The relationship with his wife and a daughter was strained. He was having trouble navigating Veterans Affairs system and he was worried about what they will offer and cover. He was unsure how to get help. He wanted a therapist. He was waiting for a case manager in Nova Scotia, as the transfer was not complete. He had problems getting worse since his Montreal stay and he wanted to talk about military experiences and some other commentary. That's what was reported on October the 24th at the

emergency department at St. Martha's Hospital.

Now just from my perspective. When I hear what his state of affairs was - his mental health I'll call it generally - when he left Ste. Anne's on August the 15th and when you look at how he presented on October the 24th suggests to me that there was a substantial and serious degradation in mental health from August the 15th to October the 24th. Would you make that similar observation?

A. That seems so, yes.

Q. And in occupational therapist language, how would you describe the change in presentation from when he left August the 15th to when he was at the emergency department on October 24th?

A. I don't ... because you're asking me in occupational therapist language. But there was certainly ... you used the word "degradation". Obviously, there was a combination of factors that led to this situation and, unfortunately, I don't have the details. I don't understand how this happened but I could have so many hypotheses of what contributed to this. But I can't really comment on this.

But one thing I appreciate, though, in hearing this is that Mr. Desmond went and asked to help because I understood he didn't ... he wasn't brought to hospital. He went to the

hospital?

Q. He attended at the hospital with his wife. It was his wife, Shanna, that took him to the hospital that day. To the emergency department.

A. Okay, so he accepted ... I don't know if he asked or accepted to go, but he accepted to go for sure since he was there. So for me there was ... I would take ... there's an indication in there of him still having some hope that things can get better. And for me, there's an indication there of support from his wife still being present. So that's, you know, positive elements in all the rest of the not-positive elements.

Did Mr. Desmond at some point decline the support that was offered that led him to be without a team for some time without any other support than his wife and his family ... his wife's family? I don't know. It's ... I don't know. His ...

(12:40)

Q. Well, the ... and I wouldn't expect you to be able to fill in the gaps that's part of what the Inquiry is trying to do is ...

A. Yeah.

Q. If at the end of the day we can make sense of it then we will certainly try and do that.

But I'd also add just a couple more circumstances. We know that ... so that was October the 24th. The next event at the hospital, to the emergency department, was January the 1st.

January the 1st Cpl. Desmond attended at St. Martha's Regional Hospital, the emergency department again, and spent the night there. He was discharged the following day and he went there, in part, because of circumstances at home involving his wife.

January the 2nd he was discharged, and of course we know that on January the 3rd he committed suicide after shooting his wife, his mother, and his daughter. It suggests to me that between October the 24th and January the 3rd there would even be, perhaps, a further degradation of his mental health so dramatic that he finds himself in that situation on January 3rd. Would that be a fair observation?

A. Well, it's a fair observation that things went at some point downward. But I can't pronounce myself on what ... you know, what did that. Was it after January 1st when he left the hospital? Was it at that point he had completely lost any sense of hope with things (inaudible)? What happened after he went on October the 24th to the emergency? What unfolded at that? What result ... what did that result in with all these observations

being done?

It could have been a situation where someone could have decided at the hospital there to call back in Montreal, even, to find out. You know, maybe we wouldn't have been able to answer questions but maybe we could have ... I don't know. It's really hard to tell. My question that comes to my mind is what happened after October 24th. There is that report that you are giving me some information that was ... and including a psychiatrist's report. That that led to what specific means of support for the family and for Mr. Desmond.

Q. Well, I can ...

A. That's really a preoccupation I find.

Q. Well, I can tell you that Dr. Slayter had decided to take Cpl. Desmond on as a patient ...

A. Okay.

Q. ... shortly after that. Actually he stepped outside of his normal role.

A. Mm-hmm.

Q. Because in his view, and in a report that he had authored, I think it was December the 2nd, that in his view Cpl. Desmond had "fallen through the cracks", and he decided to take him on outside of his normal role and had noted that one of the

important things that he needed was a copy of his medical file which would have been in the hands ... or the discharge summary, if he had a copy of it, it was in the hands of the case manager at that point in time. And perhaps in others' hands. So they were making efforts to provide some assistance. But that's as far as they got at the time. There was no effective place for, I don't think, for Dr. Slayter to go to get the information that he needed at that time so ... but we'll work towards ...

A. So am I understanding that there was ... so there was no followup at all with the OSI clinic in Nova Scotia, right?

Q. Sorry, sorry, ask me again?

A. There was no followup at that point, no active followup with the OSI clinic in Nova Scotia?

Q. He did not attend the OSI clinic in Nova Scotia, no. He had not seen a psychiatrist other than in the emergency department. He had not seen ...

A. Okay.

Q. ... a psychologist. He had just recently connected with a therapist in Antigonish in October, perhaps November, and had had two telephone discussions with a clinical case manager from Sydney. That was the extent.

A. Okay.

Q. Approximate. So ...

A. I also have ... you know, I would have questions but I mean it's not for me to ask questions. I'm just thinking. I'm just ... I just have it in my mind also. When I hear, you know, the comment that was reported that he had fallen through the cracks, what really does that mean? Because also, for me, with not having all the information, I cannot rule out the potential contribution of Mr. Desmond in the situation. At some point were there any services that were offered that he decided that he didn't want to profit from or that he didn't judge were important or that their access was too complicated?

Like, you know, it's difficult to really understand all the contributing factors when I don't have all the information. But it's unfortunate.

Q. Well, we certainly appreciate your evidence and your thoughts, Ms. Beauchesne. It all helps us address the terms of reference with regard to the objectives of this particular Inquiry.

So I'd like to thank you for appearing again today and for your re-preparation for today. It is very helpful to us to have a full understanding of what Ste. Anne's provided to Cpl. Desmond and what was anticipated would follow when he left Ste.

Anne's. You do give us some insight and that's very helpful. I, for one, certainly appreciate your time. So once again, thank you very much. We appreciate it.

Thank you, Mr. Chabot, for arranging this. I think we'll be back to see Mr. Chabot later this afternoon.

So we're going to break for ... we have that other call scheduled for 1:30? All right, so we'll return for 1:30 then. Thank you.

A. Okay.

MR. CHABOT: Thank you.

A. Thank you very much.

WITNESS WITHDREW (12:47 HRS.)

COURT RECESSED (12:47 HRS.)

COURT RESUMED (13:30 HRS.)

THE COURT: Thank you. Good afternoon..

COUNSEL: Good afternoon, Your Honour.

THE COURT: Good afternoon, Ms. Riccardi. How are you?

MS. RICCARDI: Very good, thank you.

THE COURT: Thank you. Mr. Chabot, good to see you back.

MR. CHABOT: Good afternoon.

MS. RICCARDI: How are you doing?

THE COURT: Perhaps we could ...

MS. RICCARDI: Sorry. How are you doing?

THE COURT: We're actually quite fine today. It's a lovely day in Port Hawkesbury, Nova Scotia.

MS. RICCARDI: Good.

MARIA RICCARDI, affirmed, testified:

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

DIRECT EXAMINATION

MR. RUSSELL: Good afternoon, Ms. Riccardi.

A. Good afternoon.

Q. Could I get you to state your full name for the Court?

A. Maria Riccardi.

Q. Okay, and Ms. Riccardi, we're going to start, I guess, a little bit about your qualifications. But currently, what is your occupation?

A. Okay. I have a clinic in art psychotherapy and art therapy and from this clinic I do work with Sainte-Anne-de-Bellevue, right? Working with the military and the veteran population and other clients who have anxiety or working on self-esteem. I do work at a university as well. I'm a professor and I teach art psychotherapy to students and art therapy because it's two different things in Quebec.

And also, I do work in Quebec opening programs for under-served population as children who don't have the means to bring back art in their school and in their life.

Q. So I'm going to bring up ... we have it marked as Exhibit 247, which is a copy of your *CV* outlining your qualifications.

A. Yes.

Q. Tell us a little bit about your education.

EXHIBIT P-000247 - *CURRICULUM VITAE* OF MARIA RICCARDI

A. First, I have a BA in Art Education and from that I became a teacher in school systems. So I have a diploma in Education. In 2001 I did a Master in Educational Psychology looking at behaviours, looking at learning abilities in adults and in children. In 2012 I did my Master in the United States in Art Therapy looking at mental health in (inaudible) practice and looking as well at how it could help different population through art media to help them to foster self-esteem, for example, or to have (inaudible) into the goals of their life. And presently I'm doing a PhD as a psychologist at L'Universite du Quebec in Montreal.

Q. Are you still currently affiliated with the Ste. Anne's clinic?

A. Yes, but since March, I would say, 2'18 the program has been on hold because of the COVID. So we're still discussing reopening the program after the COVID as well.

Q. And how long had you worked at Ste. Anne's?

A. From 2014.

Q. And your time at Ste. Anne's would have been dealing exclusively with members of the military or veterans?

A. Yeah, it is and it has been, for me, a very deep and emotional process as I was there from ... and I'm still there when it's going to reopen, from 2014 once a week and I used to be there at 6 o'clock in the morning and leaving at 5 o'clock every day. And I was there even at Christmastime sometimes because it is a live-in program on site.

Q. So are there any sort of unique challenges in dealing with members of the military or veterans in a clinical setting?

A. Yes, yes, but maybe to say when I started to work at Ste. Anne I had a really wonderful training at Sainte-Anne-de-Bellevue. At the time there was a clinical coordinator and we had to have an hour's provision every week and working with the group before I was able to work at Ste. Anne. It is challenging and Ste. Anne (inaudible - audio) needed support. I had training in the CBT practice and (inaudible) form practice and (inaudible) military in the art therapy program, but that was important.

And the challenge, like, would be like ... first I'm an art

therapist. So to make them understand that we're going to do art. So they always came in the session, Really? And for me it was amazing when they were able to make art in front of others, which they had so difficult challenges. It was really bringing them being vulnerable.

But for me what worked, I think, is I met them in the morning in the kitchen or in the hallway and I was there very early. So we had this kind of committee, and the art therapy was a place where it was not structure. It was unstructured. So my challenges were easier because they chose what to do. And what is hard, maybe, really is when you deal with dissociations in a session. So one who would dissociate and not being there. So to be able to challenge that with group members to get help from the team.

Other difficulties as to deal with stress, with worry, with making them feel secure. Because every time they come in they feel uncomfortable. They feel something bad is going to happen. So they would always sit looking at the door or looking at the reflection of the window to see if someone would come in. So that was the main challenge as an art therapist I would have there.

Q. Okay. I'm going to ask you a little bit about what I

was struck on your *CV*. If we turn to page 2 of your *CV*. It's listed as "National and International Presentations and Workshops".

A. Yes.

Q. It seems like you've been pretty much all over since 2013. Have you presented at some of these?

A. Yes. All of them. It's all my presentations. I wouldn't put them if not. But for me, in art therapy, I was the president of the Art Therapy Association, and I'm still (inaudible) president. I really have a lot of faith in art therapy. It was my dream when I was a child. So when I got my title I embarked on this journey and I did present conferences about the military.

We were allowed a couple years ago to present the artwork but I never present the trauma though. Always the work of art and the resilience. One of the conference I had the wonderful opportunity in Quebec to present with a military ... not on my clients. Someone else from Canada. And for me this gave me how to bring the story outside to make it understand.

Another thing, maybe relationship to our work today together, is I did present and look in States about how military (inaudible - audio) became art therapists' work in the mission

with other member of the military function. And I even looked about how art is very important in the United States, (inaudible) in Canada for now. Because it's there for longer time.

So yes, I do present, and for me it was amazing when I was allowed to present the images that were made in our session. And I have all the consent and the consent from the hospital.

Q. So it lists San Antonio, Minneapolis, Baltimore, Albuquerque, Montreal, Miami, Kansas City, Spain. These are all places you presented?

A. Yes, and maybe if COVID wants me I'm going to Lithuania in September, but let's see if I could go for COVID. Yes, for me I did a duty about trying to look about the ETC how work in art therapy and the way we could use it in different countries. And I studied in the United States. So my coworkers are from there as well.

Q. So I'm going to naturally ask you. I honestly didn't know it existed. But what is art therapy?

A. Okay. I'll try to put it in a nutshell for us because in Quebec there is a Law 21 that change name now and that separated art therapy from psychotherapy. But in many place of the world it's psychotherapy through art. In Quebec I would say

the way I work is I use media. Clay. Let's say painting. Let's say different art media that would link to help someone function to live in a session a different way of being. And being able in that way to name your emotions, your thoughts, your ideas. So creating safety and creating play.

(13:40)

And so art therapy, it is a field of mental health. It requires a Master at least, or a PhD, in Art Therapy. And a lot of the people have other Masters with that. And it requires the use of media. And we're trained because it's very ... it could be dangerous showing some media sometime that are too ... let's say too fluid because it would open too much ... too many emotions for example.

Another thing. Art therapy permits people to create and seek treatment with visual aspect of what they say, and every week when you come back the work card is there. So you couldn't remember what you did and where you're going. So it increases in some people self-esteem.

Art therapy has been here 60 years in Quebec about, as a field, and is really taking a very huge part in the world presently. Mostly the United States and Europe as well.

Q. So how does ...

A. You could ask more questions because I could continue on that.

Q. So how does art therapy sort of fit within the structure of Ste. Anne's? For example, we'll use Lionel Desmond as the most natural example. So we know Lionel Desmond has a diagnosis of PTSD, depression.

A. Yeah.

Q. Mixed personality traits were diagnosed.

A. Mm-hmm.

Q. Alcohol dependence, but in remission, and general life stressors and the anxiety that goes along with those. How does art therapy fit into Lionel Desmond's treatment at Ste. Anne's?

A. I'll start with the group and I'll bring to Lionel right away. First of all, because I work there for so many years it became unstructured. Because that was the group that didn't have talk or to be in sound ... they could have been who they were in art therapy. And strangely, when I look at my notes carefully, before the court today, he never missed a session. He worked between session and he was really motivated to be there.

So it became this place in Sainte-Anne-de-Bellevue where in the morning they have breakfast. The nurse comes. I meet with

my team before my sessions because I'm there once a week. I try to know what's happening, if there was any challenges for any clients on that week, and then when the door opens up they all come in and they all sit into a round table and there will be a lot of art materials.

And often they (inaudible) for projects. So (inaudible) I realize they start to come in and with another member start a discussion, and I never told them what to do. So imagine how hard it is to make a choice when for many months you didn't go out of your home or you were alone on the chair because of anxiety. So how it fits in, it looks about creating a secure space. It looks about helping them figure out what is meaningful for them.

And what I did ... every time I went there with Kama Hamilton we were ... I was always working with her right after my session - I had two groups on those days - to make sure that I was aware of the trauma or anything that happened on that week.

So how he fits in, I will tell you for Mr. Desmond, well, the first time ... I remember the first day because he was coming from the corridor and he had a smile. And like other veterans he walked ... they always walked towards the side of

the corridor and have the treatment build, they go in the middle, like they start taking more space and they come in in (science?). And I remember ask, What do you want to do, do you want to draw?

And he didn't for many years and for this client, he had a journal. A lot of clients don't have a journal because I try to be adapted to what they need. So for him he started making art, the first time, the first session, and I remember it was a superhero and then he said, Hey, you know, I could do it, I did it from memory.

So the way it worked for Mr. Desmond is it gives something to do, something to talk with others, and a place where he could play. Because I think that in his ... Mr. Desmond, as I got to know him, he used to play a lot before the mission. He used to be someone that was ... I think a nice, social man who used to love being surrounded with family members. And I think for me the goal with them is, Let's try to play.

So maybe the last thing I want to add is, really, that I had to be aware of anxiety because of what happened before medication. Because many ... either three or four or five clients. Sometime there were six into a group. So that's important because everybody has specific needs and they worked

within a group.

So the goals are foster self-esteem, right? And be able to be present with others and share a bit more who they are.

Q. And there's a concept of a cognitive restructuring and how ... What is cognitive restructuring? How did it apply to Lionel Desmond in this context?

A. Okay. Yes. I was trained in CBT at the same time, 2012, 2014, which in Quebec to become a psychotherapist you have to be trained in CBT. However, I don't use ... I was not hired to be a psychotherapist at Ste. Anne, and the group format did not bring ... psychotherapy means I wouldn't work on trauma, right, or on the disorders. I would work to other factors to make it feel stronger.

In art therapy it's great kind of structuring because ... the first example, when he make the drawing of his daughter on the session he drew, and he didn't like because he drew it from memory and he said, It's not her, like, she won't like it. And I remember he tear the image pretty fast and he put it aside. And then I'm like, Okay, it's your second drawing, right? It's a second time you make it. Now for my second drawing from memory it's a well-made drawing. No, I don't like it. Let's find a way to redo it.

So it's really changing their thoughts but if sometime they say, I'm no good, I would help them. No, no, artwork is not as good I would like to be but I am good. It's trying to restructure how someone sees themselves, and I'm privileged with the arts, because you have it in the moment. It's not just in the story they tell me.

So this is how I use some intervention for the CBT practice but I didn't use CBT as my main focus. I use ETC from the art therapy framework, which is working with media and neuropsychology and looking how media will help them to define who they are. Is that clear?

Q. Yeah, yes, it definitely is. So there's a concept of sense of self. So I'm wondering if you could define what that is, and from your observations, what was Lionel Desmond's sense of self?

A. Okay. Well, first I may say at the beginning, I am in Quebec a career counsellor from accreditation, a psychotherapist, an art therapist. So sense of self, it's important because in career counselling, especially with this population, I believe it was a year that he wasn't part of the military. It was only a year, and when I look for my clients when they change from military to the veteran culture they don't

know who they are and they don't know anymore who they are in the world.

So what I know from Lionel Desmond is he talked to me ... I hope I wrote more in my notes, which I didn't. That he used to have a lot of friends, that he used to like laughing with others, cracking jokes. He still did having a lot of jokes in the art therapy session. He told me he used to love playing with children. But he realized that when he was there in the art therapy, I might be agreeable to work with my daughter, making art with her, I'll be able to be the dad I want to be.

So I think this is (inaudible) how it's important to define this.

Q. So did you make any observations about his anxiety or how he reacted to sort of external stimulus?

A. Yes, I mean (inaudible) important and I'm going to ask that, you know, when I met with him his smile struck me and he was a very good nature. He cared a lot, you know? And I think that what you're asking me is how he was with others, you know? If someone will tell ... in art therapy they don't written the stories because I'm not allowed to write other stories in the notes.

But if he heard a story of a mission or someone else,

something happen, it was difficult for him to talk, to feel, and to respond. So he used to be his body. He was a bit restless. He was always on a little mode that was activated. He used to tell me, I have to learn to be there, you know? And so it was difficult for him to share about, I have a memory. And I'm trying to go with memory here about his wife. And he said they were laughing, Oh, the wife, you know guys, the wife.

And he was more doing this into this way of trying to talk more but not say too much and this maybe was because of the nature of the group. It's a group, right? And maybe ... I think you guys know at this time, but every week someone leaves, someone comes. So it's hard to create this group that is the same one.

(13:50)

So when you share too much someone else coming in the group and it's who you make ... so to tell you this, it was difficult for him, but he did have a good friend in the group. But he left, I think, maybe four or five weeks after the first part of the treatment. So with this client he was sharing more but with the group member it was difficult sometime for him to be in the moment and to respond and to have this fluid conversation.

Q. Did you make any sort of observations about ... we've

heard quite a bit about at times his mood could shift pretty fast. And did you make any similar observations about he could be happy maybe one minute, not so happy or depressed the next, or kind of agitated very fast? Cycling?

A. Okay. My observation ... and I've followed the courts, I know a bit about what's been said until now. My observation in the art therapy room if I just take the notes. Apart about two, three time when he stopped an emotion but never, I felt, that he would have leave the room or think like that. But I knew because every time he used to come in, Oh, I have to call my wife, or I have to speak with this person.

Oh, the nurse ... I used to know a bit that he used to be triggered outside the art therapy session. So I was aware. And I think this is why he choose wood-burning tools, because if, you know, if some of you make art, but when you use wood-burning tools it's a scent and it's very calming down. So when he was making art he used to be relax and he used to really feel present and away from the group because it was detailed. It was ... he liked things well done.

But yes, I was aware but, you know, when I look at my notes in the session it worked for him. Maybe not go deep into history, but it worked a feeling of sense of consistency. And

you know, like I said, I looked. He didn't miss a week since he came in. And I think even he came four days after in the other group the last week that he left. So I didn't see that mood change but I was aware there were.

Q. So how was he at sort of expressing his thoughts with others or his experiences with others? Was he open or was he guarded?

A. The truth ... well, I remember when he did the superhero and he did, like, the first work, it was about ... unless you guys have his journal. But he had a journal about superheroes and the ... a lot of the military, the veterans, they have superheroes because they are veterans in the first story in the ... and they talked about superheroes and childhood and how this is related to their life. So he was able to make this conversation.

He spoke about his daughter. I ... my memory, I think, in the wood-burning there was a horse. I think she used to train in the horseback riding or ... so he did share emotion about his life. He talks one about the mission Afghanistan. By memory I remember that. And more about what happened. Not in the trauma how they were together.

So he was able to have those conversations, but when it's

just about himself, that he didn't go there. So he had some goals, but how to achieve them ... and other clients do. And I did for the court look at all my notes with the other clients and I said, Did I write in my notes differently with others? Yes. He didn't disclose that much because it would have been said in my notes, I realized.

But he had casual conversation. He talked about some worries he had but not the whole session which was an hour and a half.

Q. So I'm going to ask you about a particular session. If we could turn to page 358 of Exhibit 254.

A. Which date it is, the session?

Q. June 20th of 2016.

A. Okay. Perfect.

Q. Just pulling it up here myself. If I could have one moment.

So in this particular session you had noted at the very last line of the second paragraph. You discuss about him working on a wood-burning project involving his daughter.

A. Yes.

Q. You noted: "He portrayed symptoms of impulsivity and reported that he has intrusive thoughts." So what were the

symptoms of impulsivity that you observed?

A. Well, I may say first ... first of all, you know, when he tear the image, like, you know, I think with this session ... I think maybe it was in this session, the session before. I'm not sure. Usually they would tell me. I would go, Oh, no, let me look at it. And he didn't give me a chance. So it was like, Okay. It was really quick. He used to feel sometime sad pretty quickly. Or you know, or some ... he would react. Like, but never into an (inaudible) matter. He named it. He said, I don't know why, you know, I ... sometimes I would react before thinking about it.

So that was impulsivity. And intrusive thoughts I should have said and worries. They are two different things, you know? But intrusive thoughts, he never named clearly what they were in nature and I had some, for example, Is my life worth living? Would I be a good dad, you know? Will I be able to go back with my family? They're intrusive because they're disturbing in nature and you want to get rid of them and they're intrusive because they come back.

He had other intrusive thoughts because again I would (inaudible) my thoughts and other colleagues. But in the art therapy room he never named them. I would say other thoughts

intrusive. And so in that session what I realized was more like, you know, when ... you know, when you make for three or four session an image about your daughter and you don't know her that much because of the mission and time that passed, yes, it wouldn't have been easy.

So that was thoughts about more about, Will I be able to get that life? You know, will I able to become ... maybe I would say my feeling is ... and maybe I'm interpretation. Who I was before, I might get back to this man. Maybe that was maybe where for me the way I saw it.

Q. So when he's reporting ... in your note you talk about he's working on a project. He tears the image and he has intrusive thoughts.

A. Yes.

Q. Am I reading that correctly that he's having intrusive thoughts while he's working on the project?

A. Okay. That's ... I thought about that question and art therapy is an hour and a half and every ... like, you know, it's a long time. So I didn't believe I made that relationship quickly but impulsivity, yes, because after we had to talk about it. I'm not going to be able to do it. So what we did is we take a carbon paper. We took a picture from our daughter. We

photocopied it. Then we put it into a wood-burning. We did it. Then he was satisfied, you know?

So we had to help him to get there. Because he said, I'm stopping, I'm not doing it, it's not going to work. So that was impulsivity. Intrusive thoughts ... I don't remember it was always on his mind. You know, I remember a man Lionel Desmond. I remember his laughter, his genuine laughter. Sometime he laughed as a defence mechanism because they all do. They told me that in the mission that's how you save your life. So he must have used it many times.

But, no, when he was working on his daughter when he made the lines he worked with it between sessions, too. Not there because wood-burning, as I mentioned ... he was calm when he was making his lines. He was in silence. It was more before or after, and because of the scope of my practice in Ste. Anne my mandate was not to bring them up. Because in psychotherapy you would maybe address them more clearly and try to work with them. But they may be some. But I don't think I wrote it that way on that session. Because of the time.

Q. So earlier when you referred to intrusive thoughts you used the example of, Am I going to be a good father, and, Is the relationship going to work with my wife? Did he share those

concepts with you?

A. With others, too. Don't forget. You know, I never was alone with him. Maybe in the morning in the kitchen table but I was not ... like, I was just saying hi and, How are you doing this week? But everything was shared, it was with others in the group. That was my (inaudible), yes, he ... you know, he was working about his daughter.

So he did show the image and talked about her horseback riding and I think, again, by memory, I was trying to find art, a concept to be with her. Because what I do with the veterans I'm a mom, too. So it's helpful, and I was a teacher, right? I tried to find intervention to do with them. But yes, he did share and I was aware of outside the sessions that that was important for him.

And you know, and I was looking at my notes, and from the first day he told me, I want this to work for me. So that was his objective. You know, so yes, he did share with other members and with me in the group.

(14:00)

Q. In terms of your time with Lionel Desmond and in these sessions what, to you, in your discussions with him and observations of him ... We have information that, you know, he

suffered from PTSD as a result of missions in Afghanistan. The question I have is were you able to get a sense of what was on the forefront of his sort of mind in terms of stressors and that was making him uncomfortable? What seemed to be at the forefront of his concerns?

A. First, you know, I think important is a lot our clients don't live there like, the whole, like, I think he stayed with us ten weeks, I believe. They don't, like, they go home on the weekend, take a plane back, you know. So what's important to think about here that he was with us every time and he saw his family, I believe, one time between the change from the first group to the second group besides (family?) on the moment.

So this was, you know, that's not only for Lionel Desmond. That's a stressor. You know, you're starting to ... I remember he became more active. He used to have a relationship with his nurse, with Julie, he had a nurse. He had a wonderful relationship with his nurse. I remember that. With the person who brought him to the airport - I was there the last day when he left - he had a good relationship.

So there was things that was working for him. Now for ... because of this he was going back to a different life. So the

stressor that I named at the time, and maybe they're intertwined to what I know today, that is to change career. It's so hard for someone who (in?) the military with, to not become someone else, because you always are a veteran, but to endorse another identity that you don't really recognize anymore or believe in. So that was a main stress, not only for him. Another stress was about a father for the first time. When they go back, and now I'm changing my life. We have to do things together. Will I be patient? Would I be able to ... will she love me? So that was another stressor that I named. And another stressor, about his wife. We didn't speak too much about the relationship because I know Kama was doing it a lot, so I was focussing on his daughter pretty much. But it was about, you know, that husband, you know, What is my ... what I'm going to do now? I think there was the financial. I think, in the military, I know it's hard when they're in treatment. Is this paid? I'm insured ... you know, they've been working for us in Canada for many years, so how I'm going to survive?

So he had a lot of worries, I called it, that were, like, typical to what I have in my session. But, for him, I think that the difficulty is every sphere of his life seemed to change. So we talked about self-concept before. So if draw a

self-concept, there is little bits in everywhere, but nothing seemed to be solid. And, with us, he's taught how to ground, I believe, you know. But then, when you're going back, I think that's what he's worried about, his worries. That's my reflection looking after the case as well.

Q. So was there ever any sort of sense of observations that you made in terms of his worry and anxiety about how he's going to fit back into his family picture with his wife and daughter?

A. You know, I think that's interesting because he wanted goals but, contrary to other members, he didn't define their goals into sub-objectives, you know. For example, I want to go back home and, you know, which day I'm going to meet my daughter. Like, there was none of this kind of, like, settled. It was more, like, I want to ... you know, I feel more active. You know, the arts, I really hoped he had ... I hoped he'd continue, but I don't know. You know, it seemed that it worked for him, strangely, because he was a creative man. So I think he had plans, but I think that what I see from my notes, it was harder to have them targeted, and that's why I'm saying there should be (inaudible) going home. And I think in my notes I wrote that it was how we going to implement it knowing where he

lives. And that's important because ... So he did not disclose how, but what, yes.

Q. Okay. If we turn to page 359, so this is a session from June 27th. It's a note, a report, that you made. If we look at the second paragraph on this note, you noted that he continued to work in silence. He worked on an image representing his daughter using wood-burning tools. Then you noted specifically, you said: "He reported that he would like to reinforce a sense of safety at the centre and in his home environment."

A. Yes.

Q. What do you mean by that, He reported something about safety in his home environment?

A. Yes, because I often do in our therapy ask, you know, So what are your goals? Because I'm thinking, okay ... because I'm trying always to work in relationship with the other members on my team, so that's why, when I say "reported", I must have asked him directly. You know, when they come at the centre, okay, first, the safety is not there right away, right? So they feel, as I mentioned before, art therapy. Who's going to come in? When they go eat downstairs, there was different members of the committee. They always sit on the front and they

leave the door slight open. So they use anxiety. What happens is they kind of reinforce their anxiety. So we try in art therapy to move them space. So when I refer in this session, because I'm at the fourth session, and now we are just changing group at the moment and, eventual, the group is for even others in the group.

So when I talk about home, and I don't remember what he said exactly about home, but what they tell me usually is, I check my door. I clean a lot. I place myself. I ... when they come home, they go check three times and, I'm like, don't go in the garbage. Try to trust it. So in that sense, he didn't have it. He didn't feel secure at home because of the aid of looking back.

I think what I meant, and I think it's important, you know when I said he was restless, something inside was always there, something, like, that doesn't make you feel present with you, and if you don't have this, it's hard to feel safe anywhere you are, you know. And, you know, I was supposed to pass in court a couple of weeks ago with you guys and I was completely not there and me and I was so ... and I said to two weeks passed and I was able to be more grounded because anxiety what happen doesn't make you feel safe. And I don't believe his anxiety went down

that much through the sessions. In session, yes, in some moments. So I think when I referred to home safety, I would never ... I would talk about you feeling safe in your environment and nothing bad is going to happen to you and nothing bad is going to happen in the world, because they have ... and what I remember, you know, it's when something is going to happen bad again. That's one thing they all tell me a lot of the time. And, you know, when I tell them in session, I'm sorry because I am very visual, but when I see them, they always tell me ... I say, you know, What are the chances something bad will happen? (Inaudible) Canada said and they even have the real data of what's happening in the world. And I'm like, Okay, this is work, like, my auto-populations. So they know too much too, in the lists too much. So this, he named it and he didn't have it, that sense of safety.

Q. Did you get a sense of how frequent him feeling insecure and unsafe and worried when he was home ... did you get a sense of if that was something that was a frequent occurrence with him, that was fairly intrusive?

A. You know, again, you know, because I'm in a group setting, I try not to dig, not to go, because I think that that would take some digging, you know. Okay, you named that. What

... I didn't go there with him, but I knew that there were some changes happening for him coming. So he did not disclose about particular events in the home. I know them but he did not disclose them. And I would tell him every time, you know, I read your note this morning. I know what happened this week. Like, the kind of note that I know too, because I think it's important in a group setting but, no, I don't remember or I didn't report specifics in the home environment.

Q. And are you able to sort of be specific on what it was about his home that he felt was tense and what he worried about?

A. Yeah. I think it would be ... I think, as I mentioned before, in my memory, is, first, there's financial, like, How I supposed to ... I'll be ... how am I support my family? Can I support my family? That was the thing that he was ... loss of faith when security is not there to start. You know, that's important. And we all with that COVID, it happened all to us when it's not clear. So that was something important.

I believe the relationship with his daughter, he really wanted her ... and it's hard for me to talk about her and them because they're not here today, but he really wanted that it worked, you know, that was important for him. So that was a worry in the home is being able to have and to have activities.

And we talked about horseback riding pretty much, so I remember that.

(14:10)

With his wife, you know, I don't have details, but I know (a little after?), when he spoke about her because he admitted ... the last image was he said to me, I'm going to go back to my wife. He said, My wife, he used to say. So I hope she's going to like it, you know. And I said, Do you want to send her a picture? You know, because he wanted to make sure that he liked both images because it's a wonderful piece on his wood-burning, he's really ... he took about 20 hours of working on one piece. We talked about a lot of motivation.

So I think he didn't specifically about his wife, but I think he was ... I believe to have a relationship, to have a situated at home. And that's all I remember.

Q. I noticed, say, through the various sessions you spent with him, there's a lot of discussion about his anxiety, his stress, his worry, at it relates to his home life and his relationship with his wife and daughter. And what appears to be absent are reports of Afghanistan and the impact that had on him. Is it ...

A. I ... yes.

Q. Go ahead. Can you reconcile that for us?

A. Yes. And I wished I did because I ... okay. We can't rely on memory, but I have a good memory, so I know he talked about Afghanistan one time, and sometime he talked to me about the bombs and how they do it and they're very specific, like, you know, and they, you know, important too, trauma is not always related to the mission which, in this case there was, but they have pleasure in those missions. And even what hurts the most, (my population?), I say mine but, anyway, the population it would be to remove that event that you (inaudible).

I should have reported more, but I didn't write that I didn't know and even when they had the discussion, yes, we had this and I was this great and I was a (inaudible). So maybe (inaudible) on sometime how to write it. And I know that his goals ... and I think it was my bias. I felt biased in me. I'm a mom and I see a lot of military want to be (inaudible) a dad. And that's precious. So I think, like, as well, I follow his focus. So I should've reported more, but there was discussion only I remember one, like, from my memory, I remember it. And there was a lot of discussion about superheroes so I remember because I went to (wall display?) between the third and the fourth sessions. I think I had one day missing and I brought

back home magazines about superheroes. So I remember we talked about it a lot, you know, so I think that was my bias in the notes, but he did talk about it. And, you know, maybe ... I didn't focus on trauma, so when this happened, they talked. It happens in my session that trauma is touched and an image comes and now I get the whole team with me. So we take that image, we talk, we have an individual session with a client. So, if, in this case, there would've been something, like, coming from the session, I would've seen him individually. I do that at the clinic. So I think this is why it wasn't mentioned. And maybe the last thing is I have, like, every time I have ten clients to write notes, I have two groups, right? So I have to look at my notes. I should've wrote more, like, I would love to be more detailed. You were right.

Q. So would you have had follow-up individual sessions with Lionel Desmond when he would express feeling tense, feeling overwhelmed, having intrusive thoughts about his home environment and his relationships with his wife and daughter? Would you have followed that up in individual sessions as well?

A. Well, when the whole team is there, when the psychologist and the social worker and anybody is there, so right away, I go see the nurse, Julie, and I would say, Okay, this came

up in the session and we make sure someone is following after that. If there's nobody at the centre or they cannot be seen, I follow up with that. So I have some clients where I see individually in this case. You know, in the session (inaudible), like, I didn't know what happened after, you know, when I was there with him. What do you report in the session where things that they all report even deeper. It's not something in the population. I mean, my clients will work for them today, they have deeper thoughts than that and more intrusive thoughts. So ... but, in this case, I did remember going to see Julie or Kama. I did remember being a butterfly in this case to make sure we'll followup because I knew what was happening outside the art therapy which, sometimes, it feels, for me, a bit it's wonderful, beautiful moment, you know, because we do feel that way and I believe the veterans and the military participate, do feel safe in the long run, you know, because of what they have created. Is that clear?

Q. Yes, yes.

A. Okay.

Q. If we could turn to page 361.

A. Yes.

Q. This is a ...

A. The date, please?

Q. This is another session ...

A. The date?

Q. ... from July 11th of 2016.

A. Yes.

Q. You noted at the second paragraph: "He discussed having difficulty to participate in the present moment due to intrusive thoughts related to his home environment. He expressed that he feels tense and he has difficulty to tolerate the distress of others." What do you mean by, again, he was having intrusive thoughts relating to his home environment?

A. I think I should've wrote "worried" in the moment. I looked at my notes and I think I should've wrote "worried in the moment" because I think it was more about, like, the differences of "worried" would be more like, you know, How am I going to do that at home? How I feel today? Am I going to be more active in my life? But, you know, if you look at the session six, okay, and he left at session nine, we are at the last phase for him of the treatment because when I went back and I believe had four sessions in the first program and he left one week before the final date. And so I think that the question that I must've brought on too is, Okay, now you're going back home ... like, I

do this in session. Oh, we have three weeks left together, you know. So that's where he's still there, you know, and now he was approaching and that, I think, maybe have a clear plan on going back home. But I believe I may ... actually wrote "worries" in the moment, so ... but it's a long time. And you know when you said to relieve the stress of others, he cared a lot. I remember about me, sometimes he cared too much about me as a therapist and about his self, you know. In the morning, taking time to how is me and ... so if people would ... in the centre how they felt, he felt it. I believe that he was hypersensitive (inaudible). So noises or too much activity would arouse him pretty quickly. And that could be due to the trauma, also who he was. I don't know who he was before the trauma.

Another thing is, like, he cared about others. And from the first note I wrote, he told me, I want to make plans. I want to have a social. I used to have people around me. I was not always like this, you know. So I think this note is relating to the way I typically write notes. Now we're going back home. How do you feel about that? Are you ready? And this is when he want to make a portrait of his wife and he said, you know, Maybe I finish this project, I could make that one. He felt like, I'll go back home. And what I just remember, remind everybody, is he

made art within session. I didn't write what he did, but he seems to have been able for him to feel safe here but, you know, in our book, when you go back home, it's not enough. That thing is that worry that he had was like, Okay, now it's real. I have to go back.

Q. So ...

A. But, you know, it's important and I think ... sorry, I think in this moment, he was more a participant, not in every part of the program, but he was more ... he was making art, wood-making. He used to really make a lot ... this was a lot because it's physical when you make wood, I think you make, like, a big project there. So I think there was, say that was happening, but now I'll be going back home. So that's maybe where I meant.

Q. Based on your reports and the frequency of the almost similar observations, is it fair to say that he sort of had an overwhelming, constant sense of worry? Would that be accurate?

A. Yes. I remember the first time I met with him, he was a lot in his head. He was a lot ... you know, it was hard. And I think maybe that's why I may have proposed wood-burning because it calms you down, you know. I think it was always there maybe fluctuating but that restlessness, I think you could see it. He used to walk ... I remember him, like not feeling grounded.

Could it be say, not feeling grounded, not feeling ... Like, I think I mentioned "in the present moment". Not being able to have this conversation and stay there, but always go in the past or in the future in his mind. So ...

Q. And is it fair to say that this, from what you observed, the fairly constant sense of worry and sensitivity, did it pretty much predominantly, from what you'd seen, revolve around his relationship with his wife and daughter?

A. Not ... about him as well. The first image was a superhero about himself, who he was, and his strengths, and he talked about being social, and I think it's something ... I think his goals were pretty accurate to what we need to be happy in our life, and I think the last image was a new goal, you know, as a ... that he ... it was the first time he's painted. I don't think it was only about his wife and his daughter. I mean, in the session, he chose (his two?) projects. So, yes, in my notes, they are there, like, I will see two-thirds of his projects, they were there, but there was other worries as well. He had many worries about it.

(14:20)

Q. If we turn to page 363, that's going to be a session from July 28th, 2016.

A. Mm-hmm. Yes.

Q. At third paragraph, you talked about again: "He's working on a portrait of his wife using wood-burning tools." You noted: "He disclosed that his goals are to create positive interactions in his social network, acquire a greater self-control, and learn to stay in the present moment." I guess, first, did he express to you he wanted to get a greater sense of self-control and what was that?

A. In self-control, we need to be able to make choices, not react to emotions right away. Be less impulsive, able to pace himself in life. I think in roles, like, he needs to pace himself because I believe a memory ... you make art between sessions, that I might too. Sometimes it's incredible the way they were by themselves, so I think it was all or nothing. And that's what is taught ... is we have taught, like, to envision all or nothing. So I think a sense of self-control and be able to recognize yourself.

One woman I work with told me a wonderful sentence I remember is, I have to learn to recognize myself, to practice being me, you know? And the self-control that he must've had in his life before wasn't there. And, you know, with post-traumatic stress, and if they have some traits, you know, if he ... I

followed, you know, I followed the court of this moment. You know, it's hard to know who you are and to have more self-control in your life, you know. So I think more in that way. And he named it, you know, because he was an impulsive man. And I would say in art therapy, you recognize that because they're more kinesthetic. They prefer things that are, like, physical, like wood-making and, you know, and you work with your body. When I gave him sensory elements, oh, that was peaceful. But he couldn't get it by himself. So, you know, so maybe why he enjoyed burning the wood, because it makes him feel more self-control. So maybe that's why we went there for that objective. And he said too that he wanted to be in the present moment because it was in his head a lot. You know, he was like, you know, so we had to create this space that he could've been there, but the worries and the anxiety makes you, so that's why we do, like, (inaudible) strategies and it was complex in all that.

And the social network, you know, he did have a little one at the centre - a small one - but it was a success. I'm like, Oh, there you go. Like, I think he had the qualities of being a friend, you know, and it's just like, you know, (learn?) aware. You get this when people work, how you get this social network that is not present. So these were his goals. That would've

been one of the last sessions we saw each other.

Q. So I'm going to turn to the interdisciplinary discharge report.

A. Yeah.

Q. It's on page 365. This is where you would've participated and made your recommendations.

A. Yes.

Q. On page 365, in the first paragraph, the last line, you say: "The client worries about his future and about his abilities to have a creative and an autonomous life." What do you mean? What was the sort of worries about his future expressed to you?

A. You know, I did mention this, but now, you know, it was ... I knew who brought him to the hospital ... to the hospital ... I knew who brought him to the airport, and he didn't want to go alone, right? He wanted to have someone that he trusted when he left. And I remember, you know, like, I believe I was there that morning but, again, memory, I'm not sure. Moving back to life after being, for ten weeks, away from everything. After seeing your family for a couple of days and trying to do things from afar, like, you know, it's very complicated. I mean, I saw them, all of them. It's complicated, this phone call but in our

therapy, Close your phone, please, because doctors have to call him back, and team, so I believe he was like, Okay, now, I'm back to real life, you know? And I think this is what I meant about his future because, How is this going to be in place for me, you know? And I worry too. You know, when they all leave, I always worry and I always ... you know, I tell my team every time, Nobody is ready to go home. Keep them here, you know. So I think, in that mention, if I was in his shoes, I would worry too because, you know, things would change when I go back. And so it's hard for them. So that's ... I think that's what I meant.

Q. And was this something ... the returning back to his family, that worry, was that sort of a top, sort of, pressing level for him?

A. No. No, it's hard because I've been following the court, right? So I've been knowing a lot about my clients. Even more than I had. But I think it was ... you know, it's hard to draw a self-concept of them trying to see, you know. So work, we're not clear what I'll do. Living. Where am I going to be living? Am I staying here? Am I going to move? You know, oh, my daughter. Okay. School is going to start and when school starts, a lot of anxiety for parents, you know.

So I think that ... I don't think it was just that. I think

that, you know, there was ... I did, after the case, but when I do my math there's not much stability that a team that receives you or clinicians, right? Nothing else was there for him in his life, you know, clearly, but I wasn't ... I didn't worry that he would've succeeded, or when this happened, I have my notes with me. I was happy he would be close. I went back the second day, the notes, right away. I didn't believe. So when I left, I saw that he was able to go back home with someone he trusted at the clinic, and the person told me that he felt he was okay to go home, you know, he didn't say, I don't want to go there. I know that he was way more physical. He was getting to be fit again. That was important for him. He was able to have relationship and for me, so you know, so yes, you go back home. But I don't think it was wife and his power was very important, yes. Might be a bigger picture, but there was other things too, it wasn't just that. So if there was ... if the other thing would've been stronger, maybe that would've took less importance but, you know, so I think there was a lot of symptoms. And his symptoms, you know, we didn't talk about today, but he had physical symptoms. You know, when you have anxiety, you think you're going to die. You know when you have an anxiety attack, and maybe some of you got one, your brain doesn't know that is because I don't get a

pay cheque. Your brain thinks, I'm going to die now (inaudible), the pressure ... time will kill me. If you have those recurring feelings about it, you know, so it's harder.

So I don't think he was ... I think it was a part of medical issues as well, and about ... and the (inaudible), we didn't talk about it. For many clients, post-traumatic stress, put it in DSM-5 as its own category a couple of years ago, right? Maybe four or five years ago, I'm not sure. Because we said it's important. It's out of anxiety now, but they don't like having minuses. It doesn't feel good because it takes who you are. So I believe there was a lot of factors about going back home.

Q. Did you notice, at page 365, in your last concluding paragraph in "Recommendations" - and we'll get to what you would've recommended - but you had said: "He would need guidance to learn to pace himself."

A. Yeah.

Q. What do you mean by that and how did it relate to Lionel Desmond? And who would provide that guidance?

A. Well, first, yeah. Oh, the second question is good. First, all or nothing, you know, I don't do nothing anymore or I train a lot. I don't clean the kitchen or, you know, we'll change a whole room, you know. So this is the all or nothing way

of thinking, you know. So this is the first thing that I think is important.

As well ... I just want to see my ... if you could just remind me of the last ... the two parts of your question. I want to make sure that I answer well.

Q. Sure. So the first was: "He would need guidance to pace himself."

A. Yeah.

Q. So what was it about Lionel Desmond that he needed guidance to pace himself?

A. And who would provide it. Art making. When they start to make art in the kitchen, and there's art everywhere, and they go for hours because, remember, they had a journal full of images, two book ... pieces of 30 ... 20 ... 30 hours each to do. Now he was a perfectionist. And when you're in the army, you have to be a perfectionist, right? You'll die, if not. So, you know, it was a beautiful part of him. I used to say perfections qualities sometimes as a veteran. He didn't pace himself, you know, he made the project ... he had time to finish his wife's portrait and then, with a painting of a new goal. He never worked on painting before and so he didn't pace himself into his goals. All or nothing. So I think I said, Okay, things worked

but at the end and things really don't ... you know, something for, you know, in art therapy you're there every session and you know if they have a session out of place it's like all or nothing. So that's what I meant.

(14:30)

Who would have provided, I think it was a team. I'm aware that you can have a big fancy team where you come out, which I would love it, you know? Not always the best, but in this case it would have been. You know, I think more time. But I think what ... how it would be, a doctor, first of all, for medication and everything to look that we're not trained for. Second, a psychotherapist or an art therapist or ... I'm sorry, an art psychotherapy or a psychologist, you know? He needed psychotherapy. He needed to change the way he saw himself. Psychotherapy means you're going to change.

So how does this create a change? And I mean it's important in ten weeks ... we're going to help stabilize everything. But there's not enough time to really work through your problems, right? It's a lot of group work. And then I would say maybe it's a social worker in this case, you know?

So who or how, it would have people reading all the reports and then looking with seeing what worked, and many veterans for

art therapy, they will call me back at the ... I have a ... first have emails about media, What should I use as media? But sometime I have reference about, Who can I have in Canada? And I work in Canada as well as a professor. So I find someone who would have the skills.

So I think that this is what I said. He has to pace himself because that view of all-or-nothing is not helpful in how you ... in a view of his life.

Q. And was it important for Lionel Desmond to have ... you talked about the benefits of art therapy and the fact that he was involved and he had vested projects to work on and see progress. Was it important for Lionel Desmond to have different things sort of lined up in his life - hobbies, interests - and why was that important?

A. Well, first, the last studies I was reading (inaudible) sort of happiness. Happiness you can only say in the studies that being married or having a safe relationship. We talk about safe relationships and this provides you more happiness. But we need to have work that you love, that you enjoy, because you cannot have just one egg in your basket. And you have to have interests and things you love.

(inaudible) was really creative. I mean all of them when

they come, and I want to ... in case someone sees me, the higher the creativity ... I believe it comes from the mission. They have in five minutes a solution for something threatening. So when they do art you know they figure it out better than me. They ... I mean I have learned more about art since I'm there than I learned myself as an artist. So yes, I think that one thing is like everything aligned, as you mentioned. Not too many things because I think school was starting. As a parent, there's so many things that you have to already do.

But yes, and I mentioned in my report and I read I strongly recommended art therapy. I never write that. It's the first time I wrote "strongly recommended". Because he came every session. Because he was able to really do stuff. Like, he left with ... he want to bring everything. There was no space in his luggage. I remember. We had to put everything there. He had all the project in wood-making, too, that he did not with me.

And I think that maybe through the media he would have been able more to touch trauma and to try to have sense of it, you know, and to make it part of his life and not away from his life. You know, a lot of time when the veteran culture and the military, they want to put trauma away but they're so invasive. So we have to help him to work with it, to embrace it, to live

with it, and he wasn't there.

So I think this is what I meant. If art was working, maybe art ... a good ... some psychologists use art, not art therapists but there are some good psychologists who use art. I think it would have been (inaudible). Because I remember the first image was a self-portrait, then family members, and then an eagle. And I don't remember why, but it could be a symbol for him because it was highly symbolic as a man, you know?

So maybe going deep with the symbol could have been helpful, and maybe I was hopeful ... that this is why I wrote it.

Q. And did his time in art therapy ... and that coupled with the individual sessions that would reflect upon intrusive thoughts, did that appear to have some success in terms of stabilization for Lionel Desmond?

A. Well, the stabilization phase was not long for him. I saw that it was ... I think I had him three weeks, and maybe he came a week before. Because the first week they don't ... they just come. They just, like it's so scary to come in. So that was ... three weeks is not very long and maybe that was due of his reflecting on it if he didn't want to take medications or just sometime we say, Okay, now we have to ... we're going to embark and looking at this and continue working on that.

I think it helped him because he did share ... well, it helped him. Let's rephrase that. I think subtly it helped him because he talked about himself. And with others, not just the psychologist or the doctor or the social work about his life a little bit more. People used to care about him, care to his story.

I remember him, too, with the nurse, in front of the nurse. They have a little nurse with a bench and they go there and chat every morning. I remember him being there in the kitchen where the coffee is. I remember him being social ... he wasn't always in his room. So it was helping now, but it wasn't intrusive thoughts, I think that we would have to look a bit more into how I feel when I'm calm, how can this be applied in my life, how can we fix some worries aside so that I could think about how I'm (inaudible). So it worked a little but not as much as we all would like it to work.

Q. Okay.

A. And you know, in ... sorry.

Q. I don't believe I have any further questions, Your Honour.

THE COURT: All right. Thank you, Mr. Russell. Mr. Anderson, do you have any questions?

MR. ANDERSON: No questions. Thank you.

THE COURT: All right. Thank you. Ms. Ward or Ms. Grant?

MS. WARD: No questions, Your Honour.

THE COURT: All right. Thank you. Mr. Macdonald?

MR. MACDONALD: No questions, Your Honour.

THE COURT: Thank you. Ms. Miller?

MS. MILLER: No questions, Your Honour. Thank you.

THE COURT: Okay. Mr. Rodgers?

MR. RODGERS: A few questions, yes, Your Honour. Thank you.

THE COURT: All right. Thank you.

CROSS-EXAMINATION BY MR. RODGERS

(14:37)

MR. RODGERS: Thank you, Ms. Riccardi. I am Adam Rodgers and I am the lawyer for the personal representative to Cpl. Lionel Desmond.

So I just have a few questions for you. I've been listening to your testimony, of course, and it's very interesting. It strikes me that the art therapy portion of Cpl. Desmond's time in Ste. Anne's may have been some of his most

valuable intervention there. Do you feel like you were getting through to him and getting an understanding of Cpl. Desmond through your time there?

A. It wasn't the only valuable, and I think that wood-making ... I think he had wood-making where they make, like, wood pieces. I think he really enjoyed it, too, and I think it was physical and I think that, you know ... and I think that may be why it was effective to start with it is because it was ... it feels good when ... when a process becomes structured. You know, like, Ahh, you know, I don't have to tell you my story.

My question is, could you repeat the last part of the question? Did it work for him?

Q. No, I was ...

A. That?

Q. The last part of the question was, I guess, did you feel like you had an understanding of him or got to know him through your art therapy work with him?

A. Yeah. I remember him clearly many years ago, and I cared a lot, you know, and ... and I was able to see the man that he described. You know, and this is what's great. And that part, you know, I really saw him laughing genuinely ... he had this beautiful laugh, you know, and like, Ohh, and he used to ...

so when he approached me I have it ... I still feel it.

And, however, it wasn't a place to get deep. And it was a lot of things happening around that. You know, the way I heard myself talking today, like a lot of thing could have been implemented like, you know, but it was so many barriers around. But I really hope, like, I (asked the court?) anybody had his images or if they found them, you know? Because there was value to what he did and I think what it gives, maybe, is to know who he was, who he wanted to be. And I think I got that, you know?

But I didn't have to deal with medication. I didn't have to deal with the trauma, and knowing this is maybe, you know, a part that, you know, I wasn't able to know that other part of him as deeply that maybe ... that other side. Is it clear?

Q. It is and it seems that ... particularly for Cpl. Desmond but maybe generally for individuals that may have some cognitive issues, brain injuries, that telling their story may be difficult. Retelling their story. But art therapy is different than that. It's not the same kind of synapses firing and connecting or not connecting.

(14:40)

A. No, and you know, one thing I find interesting is he was able to stay many hours on a task. Because interesting ... I

just look back. You know, drawing. I remember the superhero. I remember even how he looked like, you know? I wish I took pictures. It was really by memory well done. You know, sometime you could see kind of difficulties and so he had, maybe, in the frontal lobe other difficulties. But something ... he was proud. He was ... you know, the first time, I did it, I was able to.

And so I think what it gives him is ... looking at his daughter. I remember the horse. I hope I have right memories because I don't have the picture. It was a horse and a daughter in ... in her training. I think that it brought him back to his concrete life. And it does ... I mean, you know, I see that in the United States. A lot of the veterans ... one of the veterans told me once that, I had to paint blood and scars for 20 years and now I can paint flowers again.

You know, and I think you're right what you're saying. He didn't have to tell his story. But usually in art therapy later on you do start to tell your story with more security and then you mix both together. And it's less invasive because you put the work of it further when you tell to a work. So it's less distant.

Q. Less pressure to talk, too, because you can ... you're doing something and you don't ... you can talk or you don't have

to talk.

A. Yeah, and you know, an experience that didn't happen but I wish he had tried clay. But one (of the vaguely?) I remember he was (inaudible) about his (inaudible) and it was working. Because we were doing some clay ... and when you do clay, right, your blood circulates. You're not into your body. So telling your story is a lot easier when your body moves, you know? When you are sitting on the chair and with the military culture it's all straight and it's all ... like, you don't breathe. They're not taught to breathe because if you know how to breathe you will die.

So art therapy permitted them to feel at ease when they breathe. You know when I tell them, Tell me emotion, like, what are you saying? It's like, They told me for many years not to do it because it could be dangerous for me. So this is a sideway sometimes to reach someone's life in another way and you name it, you know? You say it. Okay, We'll do it that way, you know? And it works in a lot of the cases, not (all?).

Q. We heard evidence from people that knew Cpl. Desmond earlier before his military time of what a joyful individual he was, and we've heard glimpses of that in other instances from witnesses post-military. But this is another example of that.

Is that a common, in your experience, phenomena?

A. You know, I miss working at Sainte-Anne-de-Bellevue, and you know, to go there I drive an hour and a half at 5 in the morning. I feel myself in the culture because I'm so early because I live so far. I did it for pleasure. It's hard to say, I don't want to be (inaudible) my pleasure. But I become alive when I was there.

What I see is, when they come in, they laugh. I mean and then they tell me, You're not this type of art teacher, no, you're some ... they have a hard time with the word "art therapy", how to describe it, you know? But it works with many cases and I find it's because it's ... when you make art you've accomplished something. You know, anybody who made art, Oh, I did it, I'm able to do it. Oh, and it helps you tells your story.

I think it does work in the States. They have amazing programs with using dance therapy and drama therapy with military and art therapy. So that's, I think it's because they're so creative in the missions they could take that feeling back into building a project that they never did before. I think that's what happens.

Q. And it's a different way of gaining some insight into a

person's psyche a little bit, too. I mean just the subject matter, choosing the subject matter. I mean that alone is a significant choice, is it not? You know, choosing a superhero initially, choosing family imagery. You know, what does that say to you? Or what kind of common ... maybe I'll ask first. What kind of common imageries do you typically see from people starting out in art therapy and then what was the significance of those choices of Cpl. Desmond's?

A. Superheroes, they are interesting. If you read up on them a lot of them were in the military. They come from the military and that's interesting, because they do take that identity pretty clearly. And they're from their childhood. And there's a place in their childhood that they saw this and made them happy so they bring it back.

What's worked is making bracelets is they ... or they make these from paracord. You know, the cord they use in the Army, paracord that they use in the Army. They make bracelets and then they will make them and then give it to the staff and people in the military. So I think they need to give back. And when you make bracelets you're in the present moment. You cannot think about something else. It's not going to work. That's something I saw that really is useful.

I saw wood-burning a lot. I mean it was the first project about family member but they do take a lot of time. And because of the ... and some of them it doesn't work and they are reacting to smoke or to fire. So we have to ask the group, Is everybody okay with fire? And someone will tell me, Not yet, could you train slowly? Because it would ... that would be exposure in therapy. So it gives you exposure.

Other symbols I have, it's a lot of the symbols about their ... where they're from. Or their tattoos. Sometimes in the Bellevue we have a tattoo place and then they come and like, Not again, and they would create their tattoo. And one of the clients would have tell me, I'll make here ... it's ... my body could have an armour, not my soul. And they will make ... they would make a tattoo of an armour, for example, or someone they loved. They will use the art session to creating tattoos, something really strong.

I saw a lot of clay because ... and wood-carving. That's funny because ... sorry, it's a long time I'm not there now. So it's last March. But they use with carving. So it's very physical. And then I'm like, Okay, guys, well, how you took your knives, you should do it that way. They laugh at me. I'm like, You know how to use knives. But that wood-carving because of the

knives, you know? We have to be secure, put them away between session and they know. And then if someone cannot see a knife or scissors in art therapy, this happen. Okay, I'm using scissors. So ... because a lot of the trauma is relating to these knives or scissors.

So other image I saw was landscapes. Is a client that would like to go outside and would paint a landscape to try to go out and having ... work from series. And there was all kind of images, too, so ...

Q. The superhero ...

A. Yes, sorry, I ...

Q. No, that's fine. It's very interesting. I could go on, but I want to stick to, I guess, what's more immediately relevant.

The superhero imagery seems somewhat clear. This is a soldier and that's a version of a superhero in most people's eyes. Is that how you saw that opening up, or is there some other childhood connection that you identified?

A. You know what's hard because ... you could dwell on symbols and go too far, make your own thought about it (inaudible). And I wished I was deepening a bit more with him. Because I did after the session. I went to look after to what

all they meant. I said, Oh, you know? At the same time, if you go too fast it's not helpful, but he was really proud and I remember how he look like. And a name that it was from his childhood and this is what we discussed, you know the powers, what they do. They're invincible. They have a lot of life. They're hard to kill. The superhero, they save the right people. And they come from the superhero story as well. You know, the military story.

But you know, and the eagle, too. I wish I had looked, but an eagle, it's a bird. It's hope. It's engraved with symbolism. In his case it was really looking ... and then I hope his work is somewhere, because I think that he talked a lot through this, they didn't do it verbally.

Q. And the family imagery as well. I mean this is something I understand is used in family therapy and child therapy. All right? Draw me a picture of your family, and if they're standing far apart that means something, if they're overlapping that means something and all these things.

A. I don't use art therapy in that way. Very important. I don't ever do family drawing because it could hurt something there that you didn't see before.

When Lionel Desmond chose to do his family I went to Kama

and we discuss it with me and her and the team, Is it good for him, am I following him? Because we knew there were difficulties, right?

Q. Yeah.

A. And so you know, issues. In my approach with the expressive therapies continuum I look at what they choose and knowing maybe chose wood-burning because you could not talk when you do it. You have to be precise, you know? If you choose a mandala or scribbling you could talk the whole time, but wood-burning, you make a mistake. And he his well done. I remember him with him. And I'm like this, too. You know, we're doing it. We fix ... is their eyes good, you know?

You know, it's interesting to the member of the family. He never did it before but he was, I think ... and we said it today, he was at the foreground of his hopes, I think, or his wants or his desire. But in this case I never chose it like, you know, and that's why I remember making sure it was a good choice.

Because sometime I tell them, Don't you use this? Like, I don't say no, but I'm like ... you know, and we try to ... this trauma coming in. I'm like, Could we hide this, could we put it into a safe place? Could we be ... I see trigger today, you know, and we'll try to work on that.

(14:50)

And maybe the last example is I had a woman doing paint and every time she paints she would dissociate. But really, so we looked at the ... Okay, let's put paints aside, let's try to relearn how to do paint to be pleasant. And we did slowly, because the way you work, it could be harmful, too. So this is interesting. So in my approach some do it. The family drawing, we said, it's a psychologist assessment, not an art therapy assessment used by psychologists a long time ago.

But in this case family were there. I mean even a little bit more. Sorry.

Q. No, thank you. I just want to ... all right, so from everything you've said I can presume or guess the answer, I guess. But in your view, I guess it was important, or would have been important, for Cpl. Desmond to continue and to engage with an art therapist or in an art therapy group of some kind upon discharge and upon returning to Nova Scotia.

A. (Inaudible) you know ... you know, it's hard. But making art for yourself, some of them ... I had the emails sometimes, because other clinics they find me. They're not supposed to find me by other means, right? And they tell me, What's the (burner?) that we take? So I know that some of my

clients continue to make art in their life, you know?

Q. Yes.

A. And ... but you know, I think we need more than art therapists. I think we needed ... like for me we needed to ... but this maybe it would give him the sense of safety to open a door to somewhere else. But it wasn't the only door. I think this ... I think having a structure, that would have been important.

Q. All right. Thank you very much. I appreciate your evidence and ...

A. Thank you.

Q. ... the insight that you gave us today. Thank you.

A. Thank you so much.

THE COURT: Mr. MacKenzie?

MR. MACKENZIE: No questions, Your Honour.

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

MS. MACGREGOR: No questions, Your Honour. Thank you.

THE COURT: All right. Thank you. Mr. Russell, do you have anything further?

MR. RUSSELL: Nothing further, Your Honour.

THE COURT: All right. Thank you. Ms. Riccardi, I'd like to thank you for your time. I can tell you that I have

learned a lot listening to you today. I've read your *CV* and I've read some other material on the side.

But I think I have a lot greater appreciation for how you as a psychotherapist go about your work and your use of art therapy and also the appreciation of how you utilize the information that the rest of your team gathers and feeds back to you so that you are almost hidden, if you will, by your art and you are able to accomplish some positive effect on your clients, perhaps, without them appreciating it and I appreciate it takes real skill to do that.

We certainly appreciate your time today, the time that you gave to Inquiry counsel to prepare for your evidence today and I would just conclude by saying stay well.

A. Thank you.

THE COURT: And again, thank you for your time. Thank you, Mr. Chabot, for your time as well. Appreciate it.

MR. CHABOT: Thank you.

A. And just thank you. Thank you to have been here and for the family ... I'm not sure if they're able to listen. But I'm really sorry. Like as a woman, not as a therapist, you know, it's a big strategy and I think it hurt a lot of people that knew him. So I would just say thank you for being here for

you. Like I hope I could have done more as a human, you know? But you know, so I hope this will help to make some changes. So thank you so much.

THE COURT: All right. Thank you. Well, we'll adjourn briefly and return shortly for the next witness, then. Thank you.

WITNESS WITHDREW (14:54 HRS.)

COURT RECESSED (14:54 HRS.)

COURT RESUMED (15:07 HRS.)

THE COURT: Thank you. Good afternoon. Good afternoon, Ms. Blondin. Can you hear us all right?

MS. BLONDIN: (No response)

THE COURT: Hello? Mr. Chabot?

MS. BLONDIN: Hi. Yes.

THE COURT: Okay. Thank you. I just wanted to make sure that you could hear us. All right. Mr. Chabot, good afternoon.

MR. CHABOT: Good afternoon.

THE COURT: All right. Perhaps we could swear the witness in.

JULIE BLONDIN, sworn, testified:

THE COURT: Thank you. Mr. Russell?

DIRECT EXAMINATION

MR. RUSSELL: Good afternoon, Ms. Blondin.

A. Good afternoon.

Q. We had met previously. My name is Shane Russell, I'm working with Allen Murray as Inquiry counsel. I know you've heard a lot about us through your lawyer and you've provided documents.

A. Mm-hmm.

Q. I understand that you've been away from work for a little bit, so you're back I hear.

A. Yes, since November.

Q. How's it going?

A. Good. Good, good.

Q. So how many years ...

A. A bit nervous.

Q. Don't be nervous. Don't be nervous at all. You'll be fine.

A. Okay.

Q. I understand that you are a nurse, so how many years have you been a nurse?

A. For 28 years.

Q. That's a while. That's quite a career.

A. Yeah. I'm proud of it too.

Q. And how many years have you been in mental health nursing?

A. For 17 years now.

Q. And how many years have you been affiliated with the Ste. Anne's Clinic in Quebec?

(15:10)

A. For 17 years.

Q. So in your time with the clinic in Ste. Anne's, you spent considerable time interacting with military veterans?

A. Yes, I have. Yeah.

Q. And military veterans diagnosed with, I guess, all forms of mental illness from PTSD, depression, anxiety?

A. Yes.

Q. And have you seen any sort of ... how would you describe ... are there any sort of unique challenges to being involved in mental health nursing as it applies to military veterans?

A. Well, yes. I would say ... Let me see. I'm looking at my notes now. Well, what's special about our veterans is that our clients have usually experienced one or more traumas in the context of their military service. Their traumas happen often either in battle situation or in the context of protecting others, civilians, also women and children.

We unfortunately also see clients that have been harassed or sexually assaulted during their service, which makes it a little bit harder to treat sometimes but ... Yeah, so that's ... you know, a bit of difference with usually the civilians. Yeah, that makes the battle aspect of military aspect ... yes, different.

Q. And I understand that 2016 you were a nurse at the clinic in an intake capacity?

A. Yes.

Q. And are you still ...

A. I was there ac- ...

Q. And are you ...

A. I was ...

Q. Go ahead. Sorry.

A. ... the client's primary nurse. Sorry. I was the client's primary nurse, so yes, I did take the intake. I did do the intake.

Q. Are you still involved in the intake aspects of the Ste. Anne's clinic?

A. Yes.

Q. So what are the general roles of the intake nurse at Ste. Anne's?

A. Well, it's usually when the client comes in for an admission we have a nursing data collection to complete with the client. It's a tool used to gather biopsychosocial information on each client, so usually it's done within 48 hours with admission. So often it's done on the day of admission or the evening of admission and so, yeah, we have about 48 hours to do it.

If the client ... if we cannot do it the first day because the client is too anxious or whatever, so ... yeah. Or it's done by the client's nurse. And, yeah, there's questions on his mental status, general status, evaluation of behaviours at risk, post-traumatic reactions and symptoms, and knowledge of self.

Q. In terms of your interactions with Lionel Desmond in 2016, was it limited to just the intake portion?

A. No. I did his intake but I was his primary nurse, so I saw him often. I work five days a week, eight hours a day, so we would interact a lot during that time.

Q. So I'll ask you, I guess we'll begin with the intake process at it relates to Lionel Desmond. We have that marked as ...

A. Yeah.

Q. ... Exhibit 254, and it's going to start with ... it runs between pages 79 and 90. I believe you have a copy of that with you?

A. Yes, I do.

Q. And we can put it up on the screen when we navigate through various portions.

So the first page it says "Nursing Data Collection" and it seems to have five different categories. So is this a standardized intake form that is used for all veterans entering the Ste. Anne's Clinic?

A. Yes, it is. Yeah, for the clinic it's our standardized tool, yes.

Q. And this is something ... How long does sort of an intake assessment on a military veteran typically take?

A. I would say about ... depending if ... sometimes they just answer questions, they don't elaborate, it can take between about 30 minutes or so to an hour sometimes, yeah.

Q. And I'm looking at the last page, page 90, there's a

signature there in your name, and it's dated May 31st, 2016. Would this be reflective of when you would have completed the intake assessment of Lionel Desmond?

A. Yes.

Q. So I guess we'll start by going through the various portions of the intake assessment, but in particular how they related to Lionel Desmond. So the first step, number 1, appears to be a mental status exam. What does that involve generally?

A. Okay. The mental status exam is a way to observe and describe a patient's psychological functioning at a given point in time. So for this it's an admission. So it gives you his psychological state at the time of admission.

Q. I should ask, do you have sort of an independent recollection of Lionel Desmond?

A. Yes, I actually read the notes because it's been almost five years so it's been a long time. But I did receive my notes and I read them and so, you know, I mean it came back sort of, you know, how he was and when he was ... it came back to me, yeah.

Q. Okay. So if we look at page 80 of the mental status exam, I won't go over everything that you had noted, there's a particular series of spots that I'd like to ask you about, the

first under "Attitude". So what is it you're looking for as it relates to attitude during the mental status exam portion of the intake assessment?

A. Let me see. (I read?) it in my notes here. Attitude. Yes, his attitude was, as it says in there, let's see, avoiding. There was avoiding. What we mean about avoiding basically is that the answers were evasive and he avoided talking about his emotions. When we went more into emotions he avoided talking about that.

Q. In our sort of a world, "evasive" is a very big word in the sense of it's a powerful word. In your context as the intake nurse, what do you mean by "evasive"?

A. Like I said, avoid talking about certain things, not giving necessary examples or just being sort of ... how can I say? You know, talking about in general, not anything specific. That's what I would say.

Q. Overall, did you get a sense that Lionel Desmond was sort of willing and sort of forthright to share information or responses to these questions with you?

A. Yes. I would say yes.

Q. So what was it ...

A. (Inaudible - talkover)

Q. Go ahead.

A. Go ahead.

Q. So what ...

A. As I noted later about that he had tangent- ... I can't say that word - tangential speech as in like turning around. In French we say (French term) which is kind of wandering, lack of focus, not returning to the initial topic, and that's what we saw with him a lot during the hospitalization, that he was kind of avoiding in that way.

Q. In terms of ... if we turn to page 81, at the bottom of the page there's a section that says "Flow of Thought".

A. Mm-hmm.

Q. What do you mean by "flow of thought"? What are you looking for during the intake phase?

A. Yeah, flow of thought, rhythm and speed of speech. So either slow or accelerated. And the logic, is it coherent or not.

(15:20)

Q. And what observations did you make about Lionel Desmond during the intake phase about his flow of thought?

A. Yeah, like I just said he had tangential speech, so his train of thought wandered and showed lack of focus, not returning

to the initial topic of conversation.

Q. And by not sort of being focussed on the original topic, did that appear to be sort of a recurring theme in your time with Lionel Desmond?

A. Yes, absolutely. Yeah.

Q. Could you give sort of an example of what you observed in that way in relation to Lionel Desmond?

A. An example. Maybe. Hmm. I did read the notes late last night but I don't think I have really an example per se. Maybe ... Oh my gosh. I remember like reading something but I ... like the specifics of it I think may be around the relationship with his wife maybe. I think there was something about that that I read and that, you know, he was not getting to anything specifically. We were trying to find out what was wrong and ... but nothing ... he wasn't clear with everything.

Q. That's fine. I'll just sort of remind you.

A. Yeah.

Q. Don't try to ... don't feel like you have to guess or speculate on something.

A. Okay.

Q. If you don't know that's perfectly fine, okay.

A. I did read something on that, I just can't remember the

specifics of it.

Q. That's fine, there's no worry.

A. Okay. Okay.

Q. On the same page under "Mood" during the intake assessment, what did you note about his mood?

A. His mood was sad. At the intake his mood was sad and his affect concorded with the mood, which means the manifestation of the feeling. So, his affect, what he showed, concorded with the sadness.

Q. And overall in terms of your time with Lionel Desmond outside the intake assessment, did his mood have a tendency to sort of fluctuate or did it always remain sad or was it ...

A. No, it fluctuated from often either sadness or disappointment or sometimes even anger to being, you know, happy and happy-go-lucky sort of thing, and exuberant even with his peers, you know. So that's a recurrent theme that I saw in the notes and I remembered that often if something was bothering him and he would be angry about it then he would often talk about it. And then later on, then we would see something totally different, as he was a happy guy and talking, joking around with his peers.

Q. We've heard from other members of the mental health team at Ste. Anne's that one of the things he had was sort of a

rapid cycling of various moods and it could happen very fast. Is that something you observed on the unit?

A. Yes.

Q. And did you get a sense of how long ... If he was in an irritable mood, did you get a sense of how long that would last?

A. Hmm, that's a good question. I noticed like in the notes that I read that ... and when I was there, that he would be ... he would ruminate about different things that would happen.

There ... for example, one thing I remember that he was waiting for an answer from Veterans Affairs because he wanted his wife to come for a weekend and so he ruminating a lot about that. He was waiting for an answer, was not getting an answer quickly enough for him and so he would talk and talk and talk about it. And then later ... that was in the morning and then later on in the afternoon was, you know, all happy and, you know, kind of joking around with his friends. So, yeah, I would say within a few hours probably. Yeah.

Q. I just want to sort of put it in context. I'm sure many people would describe me as ruminating about things one minute and then in the afternoon I'm calm down and fine. Was there anything in particular with Lionel Desmond that was different than what you would see with an average person, I

guess?

A. Just maybe in the switch, which would be like ... he would be like exuberant, you know, not just like okay, I'm letting go, fine, I'll just change my mind, do something else. But it was ... the mood really changed from one extreme to the other basically, if I could say. You know, from being angry, irritable, to being happy and laughing out loud. So I don't know if you understand what I mean but just the extreme and difference in mood.

Q. Did you observe ... you said you described one occurrence where he was upset with the idea that maybe Shanna Desmond wasn't going to get the funding to go to visit him. Were there other sort of examples of where he would go from one mood to the other fairly quickly?

A. I think there was ... I think I noted something. Okay, okay. I think there was also when he was trying to sell his house. There was a time he was trying to sell his house and was very anxious about that because he also said that he had some financial problems, so that was on his mind a lot. So I think I saw something about that too, that he was quite anxious about that and talking about it a lot repetitiously.

And then he went ... he would go out with peers sometimes

also. Like went to the movies or to the Legion and then would come back and be the same thing, all like happy and all like laughing out loud with the peers and things like that. So it was really a difference between the two.

Q. Page 82 of your intake assessment. You have checked off "Invaded by daily living situations, financial concerns, unemployment, children, relationship issues." Were all of these present in Lionel Desmond?

A. It was mostly pre-occupations with the situation with his wife and family and financial concerns.

Q. So when you say pre-occupation with his wife and family, is that something you observed and noted after the intake assessment and during your time with him while at Ste. Anne's?

A. Yes. Yes.

Q. Are you able to sort of give us a sense of how frequent that sort of pre-occupation was with his wife and family?

A. Oh, I know it's mentioned often in the notes but I cannot put a number on it, number of times, but I know that in the notes it is mentioned quite often, but I don't have a number really, I didn't count. But it is mentioned often. Yes.

(15:30)

Q. And what sort of ... I guess there's different levels

of being pre-occupied. You could be pre-occupied in a very happy sense and speaking highly of your wife and your daughter and the good times you had.

A. Mm-hmm.

Q. How was his pre-occupation with his wife and daughter according to what you observed?

A. Yeah. At the beginning it seemed to be more in the sense where he wanted to be more involved, he wanted to be a better parent. That's what it seemed in the intake and in the first few days I would say, maybe week, after the intake.

I remember reading one of my notes of our first interdisciplinary meeting that that's what one of his objectives were, was to be a better ... I think that's what it was, a better parent and wanting to ... I think I have it somewhere where he wanted to work on his relationship with his wife.

And then as we went along in the hospitalization, it became more of a factor in his irritability I would say, because when he would talk about the relationship with his wife he would be more irritable and it would trigger anger. He would speak to her ... He would speak to her often, it seems, because in the notes it says that, you know, that he's speaking with her often and so ... and it was a factor in his irritability.

Q. And when you say speaking with her often, are you referring to speaking to her while he's at the clinic?

A. Yes.

Q. And so you got your understanding that his frequent contacts with her while at the clinic were leading to sort of irritability with him?

A. Mm-hmm. Yeah.

Q. Did you ever get any indications as to what it was that was causing him that frequent irritability in his discussions with her?

A. It's mentioned also in the notes that with the selling of the house. It's written that she asked a power of attorney because he wasn't present, he was at the clinic, so for the procedures, that. There was a time where he wanted to send his keys home, too, and that was the subject that got him upset.

What else? He wanted to ... there's one more. Another time that he wanted to leave the clinic because he wasn't getting an answer from Veterans Affairs and she kind of ... I think she seemed to wanted to calm him down and say stay, you know, and that she wanted him to complete the program before coming home. That was another thing that got him going a bit. Yeah, that's what I remember.

Q. So in it you indicated you interacted with him almost daily while he was at the clinic?

A. Yes.

Q. And you indicated you were his primary nurse, I guess?

A. Nurse, yeah. Mm-hmm. Yes.

Q. So I'm trying to gauge this level of frequency of struggling in the relationship with his wife, Shanna Desmond. Was this almost a daily occurrence or was it a weekly or can you give us a sense of how frequent that was?

A. I would say probably more weekly, not daily. Because from the notes I read there's some days that he was doing well and he was participating in groups and doing outings and going out with his peers, so it was not daily. My gosh, I would say it would be maybe every week maybe but not daily for sure, yeah.

Q. Were there periods of time when you interacted with him where he would sort of report back to you or give you an indication that things were going well in relation to his wife?

A. There were some moments, yes. When she finally came to Montreal for a weekend and his mood changed. He was quite anxious and irritable because of the procedures and all the things, he wasn't, you know, getting answers, but once she came, his mood changed. He was more relaxed, in a better mood after

that. So the weekend he told us went really well and that, you know, he was in a better mood after that.

Q. When you said there were things he was bothered by that he wasn't getting answers to, what are you referring to?

A. It's he wanted information on the current procedures to do. Like he wanted ... I think he wanted the ... her transport paid. Because often that's what happens when the spouse comes to the clinic for a weekend they can get their transport paid, so I think that was part of it from what I remember in the notes. I think that's what it was and to get the, you know, seal of approval if you want that yes, she can come, we can pay for transport and sometimes even the hotel is paid and, you know, that, so ...

Q. In terms of your observations with him day to day, how would you describe his interactions with other staff, whether it was nurses or social workers? How was Lionel Desmond's sort of attitude and interactions with them? What observations did you make?

A. With most ... I would say with most nurses it was fine. He interacted well with us. He was cooperative and calm with us. He was ... you know, he would answer the questions properly and everything.

I know there was one incident with one evening nurse at one point, where I think he couldn't find his medication and he asked them to go check in his room. And he checked in his room, came back and then the nurse told him to go back to his room to check more so I think that irritated him. But in general I don't recall anything, any ... you know. I know ... I know he ... no, I don't think. No, I don't recall any other problems with any other staff member.

Q. What about his interactions with other clients that were on the unit as well? What observations ...

A. Yeah, in general it was good. I read ... I didn't remember that, but I read in the notes last night that there was one situation with one client that he was ... how do you say? A little bit bullying a bit the clients maybe. I can't find the right word there. Intimidating, that's the word. He was intimidating with one other client. But honestly, I don't remember that at all. I read about it but most things, you know, that I read I could remember the situation, but this one thing, I don't know why but I don't remember it.

Q. Do you recall any details of ... You said, intimidating another client while at Ste. Anne's, do you remember anything about the context and what it was that he was doing that

would be deemed intimidating of another person?

A. No. No, I don't.

Q. Did you ever observe sort of any outward sort of physical signs of irritability or overt sort of signs of aggression? Did you observe any of that with Lionel Desmond?

A. Let me think. From what I can read from what I wrote in my notes, it was mostly maybe being ... I remember reading my notes. I don't remember it, per se, but I remember reading it in my notes that he was using colourful language to explain a situation that happened. I think he was talking with his wife, I believe, and it was, you know, harsh words. And I did ... I read that I did tell him to, you know, to be careful about what he says, you know. But that's the only time ...

(15:40)

Q. So when you ...

A. ... okay, that I don't remember the incident but I read it in my notes last night.

Q. So you said in your notes that he used sort of colourful words, is this ...

A. Yeah.

Q. ... colourful words in terms of is it sort of name-calling of his wife or ...

A. Yeah, I wrote in my notes the word "hostile".

Q. Hostile?

A. Yeah.

Q. And did you note sort of what it was that was hostile about his words in relation to his wife?

A. No, I didn't. I didn't elaborate on that, unfortunately. No, but he was ... I don't know what exactly he said, though, but I remember I wrote "hostile".

Q. And this, I understand, prompted you to have some sort of discussion with him?

A. Yeah, that's what I wrote, that I told him to be careful about what he says; to not use those words. But that's all I wrote.

Q. And I guess clearly if they were words that were, you know, direct threats you would have obviously had to report those, I take it?

A. Absolutely, yeah. Yeah, they were not, because I would have reported that obviously, yeah.

Q. So did you get a sense of if that was a one-off incident or was it more frequent that he would maybe have sort of a hostile description or reaction to speaking about his wife?

A. That's the one time that I wrote about it that it was

that way. He would ... I remember reading that, you know, he was upset but hostile words is the only time.

Q. And you don't remember the context of what sort of prompted that reaction?

A. No. No.

Q. In terms of his daughter, Aaliyah Desmond, and in your interactions with him, did he speak about her often?

A. Not often. I know that at the beginning of hospitalization one of his objectives was to ... he wanted to work on his role as a father, and that he seemed to love her very much, those might not have been the exact words but that, you know, he seemed, yeah, to love her very much, be very happy that, you know, she was in his life. But besides that, he didn't speak about her much, no.

Q. Did he ever express sort of any worry or insecurities as it related to his relationship with his daughter?

A. No, not that I recall.

Q. Page 82 again, under "Attention" you noted "easily distracted". What do you mean by ... I guess we take a plain understanding of that, but "easily distracted" in a sense where you're noting it as on the intake assessment. What is it about him that's easily distracted?

A. Just let me see if I can find my notes here. Yeah. I would ... it's like distracted by things around him referring to stimuli around him. Either it was like something happening around him or ... That often happens with our clients, they all respond easily distracted basically. Concentration and PTSD, also concentration and attention is very difficult, so that's a response we often get, that they're easily distracted.

Q. If we turn to page 84 during the intake assessment and there's a section ... or a section that says "Quality of Sleep" and you describe as "interrupted and nightmares". I wonder if you can elaborate what was the overall quality of his sleep and what type of nightmares and how frequent were they and how was it interrupted?

A. Let me see. As to the content of the nightmares, I noted two nightmares that he spoke about a bit about. There was one that he was being hunted and the other one that he was paranoid, but, unfortunately, I don't elaborate on that. I guess he didn't elaborate on it, but those are the two times where that I noted that ... in my notes that I wrote about it.

His sleep ... that's at the intake that his sleep was interrupted and had nightmares, that was at the intake. Later, as the hospitalization progressed and medication changes his

sleep became better. All through my notes I see that he was sleeping much better and was more rested in the morning too.

Q. So you could start to see positive effects of him taking routine medications?

A. Yes. Yes.

Q. And we have some indication that he would report nightmares often involving his wife or thoughts of harm to his wife or infidelities of his wife. Did he ever report any of that to you?

A. No. No.

Q. Did he ever express any sort of ... anything to you as it relates to concerns over his wife's potential infidelity? Did that ever come up?

A. I read in the notes ... oh, I have something. I wrote it down because it was something ... It is mentioned in the evening notes of July 2nd that he had told his daughter in front of his wife of his infidelity. And I did read that he had been ... he had thought that his wife might have been ... might have had a relationship outside of his marriage I could say. But after that he says that no, that he wasn't ... that he knew that she didn't do that but he had reported infidelity once in the notes.

Q. Okay. And you so how did this ... do you recall how this came about him telling you? So he tells you that in front my daughter I disclosed to my wife I had an affair or was it?

A. Yeah. It was in the evening notes so it wasn't during my shift.

Q. Okay.

A. It's just ... it's written in the notes that he said that. He had mentioned that he had told his daughter in front of his wife that he had ... that ... of his infidelity.

Q. Did he express why he felt the need to say that in front of his daughter or ...

A. No. No, it doesn't say.

Q. And you indicated there was some other discussion, as well, that some thought that maybe she was having affairs but then he said he didn't believe it?

A. Yeah. He said he didn't believe it, yeah. That's written in the notes too, but that's not from me. I didn't write that personally but I know that was something that he had discussed with his evening nurse.

(15:50)

Q. Okay. So if we look at page 84, at the very bottom of the page there's the heading "Relationship with Wife", and what's

ticked off here it could be "good, rare, tense, non-existing", and what's checked off is "tense". What can you tell us about that? I guess one at the intake stage and throughout your time with him while at Ste. Anne's.

A. Mm-hmm. Meaning tense with the family? Is that what you said?

Q. Yes, relationship with family.

A. Okay. He didn't elaborate at the time. I looked in my notes and he did not elaborate. Those are pretty general questions that we ask, that's in ... Yeah, it's pretty general.

Often what happens is that it's more the social worker that goes more in-depth in their evaluation. So that's what ... you know, she goes into relationship with the family, with a spouse, kids or whatever. She is the one that does that in her evaluation.

Q. And after the intake assessment, you're having day-to-day contact with him, there's some occurrences where he's using hostile language which relates to his wife, and there's discussions about beliefs of affairs, and how would you describe overall ... Did you get a sense of ... If you were to record at the end of his time at Ste. Anne's and somebody asked you to record what the relationship was between Lionel Desmond and his

wife, Shanna Desmond, how would you record it? What would you say?

A. I would say that at times his relationship was difficult with her. I actually wouldn't say that that's abnormal, we see that often with our clients. With PTSD and all the ... it's very difficult, they become very irritable sometimes, so it's ... the relationships with the spouse often are difficult.

So I would say that from what I observed, his relationship with his wife was difficult and there's also I think what came into this is that he wasn't sure ... like when he left, he wasn't sure if he would go back to live with her or not, and that was something that was really on his mind a lot. So, yeah, I would say that it was difficult at times, yes.

Q. In terms of page 85, on the intake assessment there was a section there that says, "Evaluation of Behaviours at Risk". And ...

A. Mm-hmm.

Q. ... under the section it has "Suicide" and it has a number of different sort of levels of suicide, one being no suicidal thoughts, temporary suicidal thoughts, and it goes up to immediate and clear threat and means available.

So how do you go about ... do you ask Lionel Desmond which one of these he may have? Do you go one for one?

A. No, we ask if he has any dark thoughts or suicidal ideations and if they say yes, we ask what type. But here he said he had no suicidal thoughts.

Q. And in this particular context he reports no suicidal thoughts. So when you're asking this, trying to gauge suicidal ideation, are you asking today do you have suicidal thoughts or are you asking in general have you had suicidal thoughts?

A. No, today, right now.

Q. Okay. So on this particular date, he did not report having any suicidal thoughts?

A. No, he did not.

Q. What about your day-to-day interactions with him, did he ever report suicidal thoughts to you?

A. No.

Q. And then below it on the intake assessment we have noted "Past suicide attempt", you've checked off "yes" and you noted "4-5 years ago; shotgun".

A. Mm-hmm.

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

A. Actually, he didn't elaborate on that and unfortunately

I didn't write anything about that. I know that ... I don't know why, but maybe I probably should but I didn't write anything about that and he did not elaborate.

Q. So how does this come about? You ask him: Do you have any suicidal ideation or thoughts now; he tells you no suicidal thoughts.

A. Mm-hmm.

Q. Then do you ask him did you have any past suicide attempts?

A. Yeah.

Q. And that's when this was disclosed?

A. Mm-hmm.

Q. And when you noted "4-5 years ago; shotgun" the timeframe 4-5 years, 4 or 5 years, that comes from him?

A. Yes.

Q. And this reference to a shotgun, that comes from him as well?

A. Yes.

Q. Did you get ... you know, I realize that it's some time, but did you get a sense of he actually, you know, possessed or fired a shotgun or he took it with him in this suicide attempt? Do you remember any of that?

A. No.

Q. Is that something that normally it's pretty material perhaps to note? If you're evaluating behaviours at risk and one is suicide and he discloses a past suicide attempt with a shotgun, are the details generally important?

A. Yes. Yes, they are.

Q. Do you know if you had noted anywhere else the details of this?

A. No, I did not.

Q. So this intake ...

A. He didn't ...

Q. Go ahead. Sorry.

A. He didn't elaborate more on that.

Q. So this intake assessment that was done May 31st of 2016 and it says "Past suicidal attempt 4-5 years ago; shotgun" who does this intake assessment get shared with at Ste. Anne's?

A. It gets shared with the team during our first interdisciplinary meeting about the client.

Q. In terms of your role as one intake nurse and your role as primary nurse interacting with him every day, what is the importance of noting this down to have it shared with the psychiatrist, the psychologist, the social worker? What's the

significance? Why do it?

A. Well, it's important so that ... well, all the information ... well, the most significant information I would say of the data collection is shared with the interdisciplinary team so that, you know, each professional knows how at that point in time how the client was and what were his answers and what are the basic ... what are his needs. Yeah, that's it.

Q. In your experience interacting with military veterans when you're having sort of one-on-one discussions or trying to gather information with them, is it a common occurrence where they might disclose things to one mental health professional and they might not disclose to another?

A. Yes, that happens.

Q. Do you have any sense of is that something that's one in a thousand or well let's ... or frequent? Do you have any sense of the frequency of that?

A. I would say it's frequent, yes. Sometimes, you know, depending on what it is, you know, sometimes they might disclose, for example, a traumatic experience with a psychologist because that's what they're doing, example exposure therapy with the psychologist, and they don't necessarily want to share it with the other professionals. You know, often we hear, Oh, no, I

don't want to repeat my story again, I don't want to. So, often, yeah, they do share things, certain things, with one professional and not with another.

(16:00)

Q. And, perhaps, is this part of the importance of sharing this along the way, this ... your notes get passed on?

A. Yeah. Yes, yes.

Q. And I perfectly recognize that you are not law enforcement at all.

A. No.

Q. So when you record something like "suicide attempt with shotgun", I notice above when you're asking questions about suicide, it says, "Immediate and clear threat and means available". So when you hear that sort of information, do you normally, in your course, say, Do you have firearms at home or do you have access to firearms?

A. Yes. We should, yes. When it's, in the first part, when they say that they do have suicidal ideation, we do ask about the means, yes.

Q. But when he discloses that he had a past attempt and it involved a firearm, do you recall if you asked whether or not he had access to firearms?

A. No, I did not.

Q. Would you normally have asked?

A. Well, we have to take into consideration also that they're military so, often, they do have arms at home. I would say I probably should've asked, but I don't think that we do necessarily ask, like, you know, in the past that's just ... yeah.

Q. That's perfectly fine. I'm just asking what the process is.

A. Yeah, yes.

Q. So if we look at the next set of questions under "Evaluation of Behaviours at Risk", page 86 ... I guess, before I get there, during your encounters with him after the intake assessment, is there any other discussion about past suicide attempts or firearms with him?

A. No.

Q. If we turn to page 86, the next heading under "Behaviours at Risk", "Expression of Anger Behaviour". And the question is, "How does he react to an unforeseen situation?" And what's ticked off is "panic and anxiety". So what is meant, and is it explained to Lionel Desmond, what an unforeseen situation is?

A. Yes, we usually explain because they usually ask us what that means. So it's when something happens that you're not waiting for it. Sort of, if something comes up and you weren't prepared for it.

Q. And he disclosed his reactions would be panic or anxiety.

A. Mm-hmm, yeah.

Q. As opposed ...

A. Which is something that we see often.

Q. And did you get a sense of, in your interactions with him, did you see that actually play out? Something might've unforeseen occurred while he was at Ste. Anne's and he reacted in a similar fashion?

A. I don't have, like, a specific example, but, from what I read in the notes, yes. Anxiety.

Q. Okay.

A. Yes.

Q. The next question is, on the same page, "How does he react to frustration?" And there's several boxes and you noted "anger". And then you wrote, "Has to leave because anxious." Is this something that he's reporting to you?

A. Yes.

Q. Did he give examples of sort of situations where he had to leave a frustrating situation?

A. I can't recall any incident, no.

Q. And did you see, in your interactions with him, how he reacted to periods of frustration?

A. From what I could see is that he reacted with a lot of ... he was ... he became irritable and frustrated. Yeah, very irritable. What else can I say? Became anxious too and would, like we said earlier, would ruminate. Yeah, that's what I would say.

Q. Below that, there's a heading called "Tolerance Threshold". What's "tolerance threshold"?

A. So tolerance is the range that the person is under control that their, like, say, anger is manageable within limits, and the threshold is the limit. So it's, like, kind of the space between the two there.

Q. And you noted him as "low". What gave you the impression that his tolerance threshold was low?

A. Well, he told us that it was. And that's something we see with most of our clients that their tolerance threshold to anger or to frustration is quite low. Their patience level is low. I mean, you know, with PTSD, and that's one of the

symptoms, like, you know. We often see that. And what I could see from the notes, also, is that as soon as something wasn't going his way, that's when he got frustrated and anxious and irritable.

Q. And that was something you observed throughout his time at Ste. Anne's?

A. Yeah. Mm-hmm, yes.

Q. Under "Violent Behaviour", there's a zero with a slash through it. So that's, I understand, maybe no reported violent behaviours?

A. No reported violent behaviours.

Q. If we turn to page 87, under "Use and Habits", there's "alcohol and drugs". And, again, it's a similar ... I guess, if you could tell us what was reported there.

A. Yeah. He didn't report any tobacco use, alcohol, drug use, or gambling. Caffeine was just green tea once a day.

Q. So when it comes to caffeine, he elaborates further and tells you that he actually drinks green tea once a day?

A. Yeah.

Q. And when you turn to the topic of alcohol and drugs, did he tell you he didn't consume alcohol or did he talk about the frequency?

A. He said that he didn't consume alcohol.

Q. What about drugs; say, cannabis? Did he report that he used ...

A. No. Never mentioned. Never mentioned cannabis.

Q. So we know from Dr. Ouellette, who was the treating psychiatrist at Ste. Anne's, he was discussing with Lionel Desmond that he would consume up to 12 beer a day, which is quite a stark contrast to what he reported to you.

A. Mm-hmm, yeah.

Q. Did you get any sense of whether or not Lionel Desmond was being as forthcoming with you or was he being evasive in any way?

A. Well, we have to think that the intake is taken at admission, so we don't really know him very well so, you know, we take into account it's a self-reporting, so that's what he tells us, right? But, you know, that's, you know, many clients report that they take alcohol or drugs prior to admission in order to self-medicate, so that's ... I'm not surprised that he actually said that to Dr. Ouellette because we hear that all the time. They self-medicate before they come to our clinic because they're not well. So I was not surprised of that, no.

(16:10)

Q. Okay. If we look to page 88, there's a section that says, "My Post-Traumatic Reactions".

A. Mm-hmm.

Q. And it says, the second one, "I have bad dreams since the event". And it's checked off "yes". Do you give a discussion of the event? How does that come about? How do you discuss that?

A. We don't necessarily ask for, like, examples. Or, often, they don't want to actually speak to us about the event. So it's more in a general sense. The questions are more in a general sense.

Q. And below it in this intake, "I have flashbacks of the event". And it says "rare".

A. Yeah.

Q. Again, we know, from his interactions with other professionals, that he talked about having fairly frequent sort of recurring flashbacks.

A. Mm-hmm.

Q. Would you say that this is sort of unusual or how do you reconcile the difference here?

A. From what I can see, he has most of the symptoms of PTSD. He did say later - I saw later in the notes - that he did

say that he had intrusive thoughts or flashbacks. So what I'm wondering here is that did he really know what it meant. Sometimes, you know, they ask us, What's the difference between intrusive thought and a real flashback? So I'm wondering if he actually knew. And I didn't write that, you know, if I discussed that with him, but that's what I'm wondering about. But he told us he did not have them and, as I said, it's an intake, so it's, like, the first day of the mission, so we ... you know, I didn't know him. But, usually, they do have flashbacks, but it happens sometimes that they don't, not very often.

Q. And in your time with him after the intake, did you get any sense that he was having flashbacks?

A. Well, every morning, we try to ... the nurse meets with the client to do, like, a little, you know, a little evaluation on his mental and physical state. And he did mention that he had, it was mostly like intrusive thoughts that he had, but he did mention. I wouldn't say every day, but he did mention a few times that he did have flashbacks or intrusive thoughts.

Q. Did he say what the flashbacks or intrusive thoughts were, like what did they involve?

A. No.

Q. One stood out to me in this recorded reactions. It's

probably six from the bottom and it says, "I have the impression that I have nothing else to expect from life." And it's checked off "yes". What are you looking for here?

A. We see that often also in PTSD and depression. So that's ... we're looking for, I would say, maybe depression symptoms. That's what we're mostly looking for. The next page, also, there are notations about different depression symptoms. So that's what we're looking for.

Q. So I'll go through these below it very quick.

I have more difficulty sleeping. I feel more irritable. I am having trouble concentrating. I feel constantly in a state of alert. I am very nervous and I am very easily startled. I feel constantly sad. I lost a lot of weight. I have a loss of interest for everything. I feel guilty all the time. I put myself down all the time.

How did he answer all of those questions?

A. Yeah, most of them are "yes".

Q. And one question, the next one, "I often think of death". And what was his recorded answer?

A. "Often think of death". He said, "Sometimes".

Q. In your time with him after the intake, was there ever any sort of conversations with him about how he was doing and was he still thinking of death?

A. Like I said, every day, we have ... we meet the client to see how he's feeling and to evaluate his mental and physical state at that present moment and we always ask about suicidal ideation and how, you know, how he's doing with that, and he always said, No, he didn't have any suicidal ideation or plan or intention of any kind.

Q. Okay. And 14, 15, and 16 on this "Other Possible Symptoms". "My relationship with my spouse is very difficult right now. I'm experiencing strained relationships with my family. My relationships with my friends are frustrating and deceiving." What were his answers to that?

A. All "yes".

Q. And in your time with him, were any of these sort of reflected in your interactions with him about the difficulties with his spouse, the strained relationships with his family, and friends and family, believed that it was frustrating and deceiving?

A. It was mostly about his spouse, I would say, that we observed that there was some tensions there.

Q. Were there aspects of ... where he checks off, "My relationships with my friends are frustrating and deceiving", was there any sense that you got that he believed his wife was deceiving in any way?

A. No, I don't believe so.

Q. In terms of the discussion with the finances, did he have any, or hold any, beliefs about her managing the finances?

A. He didn't speak of that. He spoke that he had, you know, financial problems but he didn't ... with us, he didn't elaborate much on that. It's more the social worker that asks, that evaluates that point. But, oddly enough, what I saw, so that he would go out often with his peers and go to the movies, or go fishing, or go - you know, fishing, you need a permit - or go ... outings, you know, shopping or things like that. So, yes, there was this aspect of financial, that he said that he had financial problems, but, in another way, he would go out often and, you know, to these places where it cost money to go to. So I'm just trying to kind of ... you know, there was a ... that's what I noticed yesterday, by reading the notes that, yeah, he did have financial problems, but he did go out a lot and seemed to spend money too.

Q. I'm trying to find the section, but I can't seem to

locate it. At one point, there was a section for him to indicate "yes" or "no", and the question was, "Have you ever felt the loss of control related to internet use?" Do you recall if that's part of the questionnaire?

A. No. I know that there's a part that is called ... page 8, that we check for suspicion of drugs or alcohol, but, actually, we don't ... that's been ... it was put in the data collection, but we didn't actually use it because we had an addictions counsellor. That was part of his evaluation to do that, so we didn't really do it. But there was no ... no, I don't recall any of that.

(16:20)

Q. Did he ever give you a sense of ... We sort of now know that he was quite frequently texting Shanna Desmond in the run of a night. It could be upwards of 400 texts. Not all pleasant. Did he ever discuss that with you, sending her repeated messages?

A. No. No, that I don't recall at all.

Q. And page 90, which is the last page of the intake assessment, there's a question of, "Are there things in particular that would incite you to react strongly?" And what does he record as things that would incite him to react strongly?

A. "Watching war or action movies" and "arguing with wife".

Q. Did you sort of, in your time with him, did you sort of pursue those two things that he said would incite him to react strongly? What it was about war or action movies and what it was about arguing with his wife that would cause such a strong reaction?

A. My gosh, I would say I don't remember.

Q. And below ... did you sort of observe ... did it seem, when he's describing his relationship to you with his wife, or you're having some general conversations, did he seem to have a strong reaction to that? His relationship with her?

A. It was mostly him that would talk to us about what happened, you know, either he spoke to her and he was triggered by something or it was ... in a situation, like, let's say, the selling of the house or ... it was more about ... it was more him that was coming to us and talking about it.

Q. I guess, sort of looking back, we know that he also had murdered his mother and daughter. Did he ever speak of his mother at all in his time with you at Ste. Anne's?

A. No. No.

Q. Did he ever sort of have strong reactions or anything

stood out to you as it relates to his daughter whenever he would discuss things about her?

A. From what I can see, it was happy thoughts, if I can say, about his daughter. Only good things. That he said he wouldn't talk much about her. I don't know why, but I don't recall him talking a lot about her, but it was always positive and, yeah, he was happy when he spoke about her.

Q. And then below that, there's a section called "Triggers". What did he report to you that could be triggers for him?

A. Yeah. People of Arabic descent, raw meat and flea markets. And that's something that is not unusual with the different missions that our clients go on. So that's pretty ... I would say, pretty typical for a client that went on missions. It's something that we hear a lot about. Those are triggers that, you know, that would trigger them, yeah.

Q. And, finally, under "Dissociative Episodes", under "Description", you noted, "tune out". Is that a phrase that he would've used?

A. Yes. He was the one that said that. And we do see that often with our clients too. Sometimes, you know, we're having a discussion with them or ... and we just see that

they're tuning out, basically. They're just, they're there, but they're not really there, you know. So that's how we characterize it as tuning out. So that's a dissociation.

Q. And did he ever sort of ... there's, I guess, there's everyday language of tuning out to the point of sort of not paying attention.

A. Mm-hmm.

Q. Did he ever describe to you any sort of almost surreal experiences where he feels like he's sort of left his body and he's not there?

A. No.

Q. No, there was no sense of that?

A. No. No.

Q. And did you sort of make any ... You've been around patients before that have had psychotic or dissociative episodes.

A. Yes.

Q. And you were ...

A. Yes, (inaudible - audio).

Q. I guess you know it when you see it.

A. Yes.

Q. And did you make any of those observations with Lionel

Desmond?

A. No, not at all.

Q. Thank you, Ms. Blondin. Your Honour, I don't have any further questions.

EXAMINATION BY THE COURT

(16:25)

THE COURT: I have one question. I may as well ask it now. If we could turn to page 91, please.

A. Which page, sorry? Okay, yes.

Q. It's page 91. It's the PTI. The date, it's in the top section. It deals with the date "16-07-08".

A. Mm-hmm.

Q. The time looks like it's 15- ...

A. 50.

Q. 15:50 hrs.

A. 15:50, yeah.

Q. Can you tell me what the notation is? It's at ...

A. Sorry, what did you ask me? I'm sorry, I didn't understand.

Q. Oh, I'm sorry. So I'm going to get you to translate the note for me. It's an escalation ...

A. Okay.

Q. ... and frustration and irritability, and then ...

A. Yeah, yeah.

Q. ... there's some other words there.

A. Yeah. "Tornado warning".

Q. And ...

A. That's ...

Q. Go ahead.

A. Yeah. That's ... my colleague wrote that, actually, I did not write that.

Q. Okay.

A. My colleague wrote that. I think that was when the actual incident happened with my colleague. I think that's when he wrote that.

Q. Was that over the ... was that the medication event?

A. Yes, I do believe.

Q. Okay. And further across on that line, what's the rest of the notation say? It looks like something ... it looks like, "SI" and something else.

A. I think it's "soins infirmiers", so "nursing" in English.

Q. I'm sorry, it's "nursing"?

A. Yeah. In French, it's "soins infirmiers", which means "nursing" in English, yeah.

Q. All right. So the words "tornado warning", can you translate what that might mean, knowing that your colleague wrote it and perhaps having some idea of how your colleague thinks about those events?

A. Yeah. I think it's something that the client said, but I wasn't there, so I can't really explain it because I think it's something the client said, but I wasn't there, so ...

Q. All right, thank you. That was my short question.

A. Okay.

Q. Mr. Anderson, do you have any questions?

MR. ANDERSON: No questions, Your Honour, thank you.

THE COURT: Thank you. Ms. Ward?

MS. WARD: No questions, Your Honour.

THE COURT: Thank you. Mr. Macdonald?

MR. MACDONALD: No questions, Your Honour.

THE COURT: Thank you. Ms. Miller, do you have any questions?

MS. MILLER: Yes.

THE COURT: All right, thank you.

CROSS-EXAMINATION BY MS. MILLER

(16:29)

MS. MILLER: Good afternoon, Ms. Blondin. My name is Tara Miller and I'm counsel for the personal representative representing Cpl. Desmond's deceased mother and his deceased daughter.

My questions are really discreet. If I understand your evidence with my friend, you indicated that, during intake he was preoccupied with, really, two things, his family and with financial issues. Correct?

A. Correct.

Q. Yes. And then, later, you were talking about irritability because he wasn't able to get answers. And that irritability had nothing to do with his wife. Indirectly, it did, but, directly, as I understood it, the irritability had to do with getting a response from Veterans Affairs about funding, a financial consideration with his wife coming to visit him.

A. Yes.

Q. Okay.

A. Yes, correct.

Q. You then indicated that Cpl. Desmond spoke about having financial problems a lot.

A. Mm-hmm.

Q. But, from your perspective, he would go on outings and spend money. That was your observation.

A. Mm-hmm. Yes.

(16:30)

Q. And you referenced, for example, a fishing outing that he needed a permit to go on? Is that correct?

A. Mm-hmm.

Q. Was that the example that ...

A. Yes. I believe I read that he did ask our foundation, the Veterans Foundation, for money for that, but it doesn't say, later in the notes, if he got it or not, but I just remember that, that he ... there was a ... that he asked for that.

Q. So is that the only example that you have of him spending money was on the fishing permit?

A. There was shopping too. He would go shopping with his peers. He would go to the movies. He went to the movies often too. Those are two other examples.

Q. Okay. Just to help you, you had referenced he had asked ... in the notes, you looked ... that he had asked the Foundation for money for the fishing permit. And it does appear, from a record in the Ste. Anne's Exhibit 254, at page 393, it

does appear that he was given that monetary donation from the Foundation. I don't know if you've had a chance ...

A. Oh, okay.

Q. Okay.

A. I didn't know that. I didn't remember that he actually had it.

Q. Okay.

A. It's not written in the nursing note so ...

Q. Fair enough. The last thing I wanted to ask you about, you said, during intake, you'd ... it was around the topic of nightmares and you said your review of the notes were that there were two types of nightmares; one, that he was being hunted.

A. Mm-hmm.

Q. And I think the other one you said was just another around paranoia. What do you remember about his nightmare about being hunted?

A. No, I don't.

Q. You have no recall.

A. I don't remember, no.

Q. Okay.

A. No.

Q. But that it was a nightmare he was having that he was

being hunted.

A. Yeah.

Q. Okay. And then another one relating to paranoia. Do you have any detail around the paranoia in the nightmare that was referenced?

A. No, I don't, sorry.

Q. Okay. And when you say you reviewed your notes to help refresh your memory, you don't have any memory independent of your notes. Is that fair to say?

A. That's fair to say, yeah. It's been a long time.

Q. Yeah. And ...

A. And we see many clients go through the clinic, so, yeah.

Q. Fair enough. And you would chart your notes. You said you worked Monday to Friday, 8 to 5 - I think those were your hours - five days a week?

A. No. I work five days a week, but it's not Monday to Friday because we work every second weekend. So it varied, my days varied, but it's basically five days a week, but not from Monday to Friday, and it's from 7:15 to 3:30, my shift.

Q. So in preparation for today, did you review all of your chart notes?

A. Yes, I did. I tried to read everything.

Q. Okay, fair enough.

A. Yeah.

Q. Are your chart notes all in French, Ms. Blondin?

A. Yes.

Q. Okay. During your review of your chart notes and the other nursing chart notes, did you have an opportunity to review any comments or recordings from Cpl. Desmond about any head injuries that he sustained during the course of his military service?

A. I saw one note. I can't remember though. But I remember seeing one note about that. I think it was probably in an interdisciplinary meeting, probably, because I write down what we discuss in the interdisciplinary meetings. I believe it's in that. It was kind of late last night when I finished reading the notes but I think it's probably in an interdisciplinary meeting that we discussed that.

Q. Okay.

A. Because that's what I do. I write about what we discuss so ...

Q. I'm just ...

A. But I don't think he discussed that directly with us.

Q. No. Okay. So I just, for the benefit of the Inquiry, I'm going to take you to page 145 - of what I understand to be nursing notes - of Exhibit 254, and I'm looking at the bottom of page 145, Ms. Blondin, and correct me if I'm not interpreting this correct. This is June 30th, 2016, at 14:30. Did I read that correct? Can you see it on the screen?

A. June 30th, yeah. Those are not my notes, by the way.

Q. I know, because they're in English, so that's why I was able to read them but ...

A. Okay, yeah.

Q. ... these are nursing notes.

A. Yeah. I have one colleague that's English, so she ...

Q. Yeah, these are nursing notes.

A. ... writes it (inaudible - audio).

Q. This would be from one of your nursing ...

A. Okay, yeah.

Q. ... colleagues. Correct?

A. Yes, right, yes.

Q. Okay. And it says: "Met with patient for evaluation. States he slept good." Looks like: "No nightmares. No intrusive or dark thoughts. No flashbacks. No anxiety. Patient states his mood is good. During interview, patient stated (it

goes on to say) I think I have PTSD with a touch of bipolar." Then the very last sentence is: "Patient also stated that he might have (I'm trying to decipher that) ... that he might have head trauma." And then if we turn to page 146 ...

A. (Inaudible - audio.)

Q. "Has hit his head." At the very top.

A. That's where it is. Okay. I couldn't remember where I read it. That's why I said that it might've been in an interdisciplinary meeting because that's what ... that's where we would discuss such things, but it looks like it's in my colleague's notes. I'm sorry. My bad.

Q. No, that's okay. So it says: "Has hit his head multiple times in accidental situations. Stated once when he rolled a LAV combat vehicle." Then it goes on to talk about some other things.

So that would've been taken by one of your colleagues, and you read it last night but, other than that, do you have any recall of Cpl. Desmond telling you anything about a head injury?

A. No, not at all.

Q. Okay, thank you, Ms. Blondin. Those are all my questions.

A. Thank you.

THE COURT: Mr. Rodgers?

MR. RODGERS: Thank you, Your Honour. No questions, Your Honour.

THE COURT: All right, thank you. Mr. MacKenzie?

MR. MACKENZIE: No questions, Your Honour, thank you.

THE COURT: Thank you. Ms. MacGregor?

MS. MACGREGOR: No questions, Your Honour.

THE COURT: All right, thank you. Ms. Blondin, I had one question, but I already asked it, as was my prerogative, I guess. So I think that we're finished here. I think that all the counsel have asked questions. Mr. Russell has no more questions for you.

I appreciate, as we all do, the fact that you are newly returned to work and you took the time yesterday to review your notes so that you would have refreshed your memory and have some recollections for us, which are important. We, of course, have your notes here as well and we can rely on those, but your personal observations and interactions with Cpl. Desmond are very important to us, so I'd like to thank you for your time and hope that you enjoy returning to your workplace.

A. Yes. It's a different situation because of the COVID. Our clinic closed in May, last May, so I've been, like, around.

I've been to one place and another and another, but I came back to Ste. Anne's in December and was very happy about that.

Q. Well, I'm sure we're all pleased and I think we would all be more pleased if we could all get back to the way we were a year ago. More than a year ago.

A. Yes.

Q. And, hopefully, that will happen soon. And, Mr. Chabot, again, thank you for your time. We appreciate your assistance in arranging for the witnesses to appear. Thank you.

MR. CHABOT: Thank you, Your Honour.

WITNESS WITHDREW (16:39 HRS)

THE COURT: So we will conclude the evidence there. I understand that, for tomorrow, we have Mr. Greencorn?

MR. RODGERS: Yes, Your Honour, that's correct.

THE COURT: At 9:30?

MR. RODGERS: At 9:30, yes.

THE COURT: And Mr. Greencorn is going to appear in person?

MR. RODGERS: He'll be here in person.

THE COURT: All right, thank you. And then I think that would likely be the evidence for the day, and then we will have our discussion after Mr. Greencorn concludes. All right?

MR. RODGERS: Very good.

THE COURT: All right, thank you, Counsel. See you tomorrow morning.

COURT CLOSED (16:39 HRS)

CERTIFICATE OF COURT TRANSCRIBER

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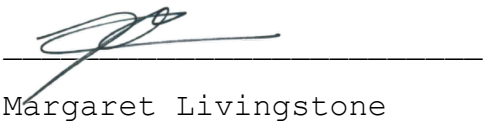

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