CANADA

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF THE

FATALITY INVESTIGATIONS ACT

S.N.S. 2001, c. 31

THE DESMOND FATALITY INQUIRY

TRANSCRIPT

HEARD BEFORE: The Honourable Judge Warren K. Zimmer

PLACE HEARD: Port Hawkesbury, Nova Scotia

DATE HEARD: April 19, 2022

COUNSEL: Allen Murray, QC, 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

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

INDEX

APRIL 19, 2022

COURT OPENED (09:31 HRS.)

THE COURT: Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Counsel, we're here today, tomorrow for oral submissions, which will, I think, effectively bring the Inquiry to a natural conclusion, for a period of time, at any rate.

This morning we are going to hear from Mr. Murray and then Ms. Ward. We will take a short break between the submissions. Then this afternoon, I think Mr. Anderson?

MR. ANDERSON: Yes.

THE COURT: Mr. Anderson and Mr. Rogers, this afternoon. All right. Thank you, then. Mr. Murray?

MR. MURRAY: Thank you, Your Honour.

Your Honour, before making my final oral submissions, I do want to take a few moments to comment on I guess the experience of having participated in the Desmond Fatality Inquiry.

First of all, I would like to take a moment to thank you, Judge Zimmer, for the guidance, direction, and vision that you have provided during the Inquiry. The relationship of the Inquiry judge and Inquiry counsel is quite different from that

of judge and counsel in a traditional trial setting. While Inquiry counsel need to have a measure of independence and, of course, must remain impartial counsel and judge at an inquiry, I have learned, also work together as a team to guide the process and present the evidence in a meaningful and helpful manner. I have found the experience of working with you to be both professionally fulfilling and personally enjoyable.

I want to thank my employer, the Public Prosecution Service, for the unique opportunity to have worked on this Inquiry. When Martin Herschorn, then the Director of Public Prosecutions, approached me to see if I would be interested in acting as Inquiry counsel, I said candidly that I had never participated in an inquiry in the past and, frankly, did not have a detailed understanding of what would be involved. So it was, to say the least, a leap of faith but it is one that I am very glad that I took. Despite dealing with subject matter that was, at times, disturbing and painful, this process has been both a gratifying professional experience and a tremendous learning opportunity.

I want to take a moment to thank Inquiry staff, in particular, Elise Levangie and Selena Acker for their hard work and assistance throughout this process, which has made the work

of counsel so much easier. A large volume of documents were ingested and catalogued. During the hearings, documents and exhibits were pulled up on the screens seamlessly. They made that look easy when it was anything but. In reality, it was the result of hard work and great organizational skills and, in short, we could not have done our work without them.

I also want to take a moment to speak about the counsel who have been part of these proceedings. My former co-counsel, Shane Russell, now The Honourable Judge Shane Russell, worked with me through much or most of the Inquiry and his input, hard work, and contribution were extremely valuable.

In this room and in the previous room, there have been a dozen or so counsel throughout the hearings. Some of these counsel I knew before the start of the Inquiry and others I have come to know, but all of them have been a pleasure to work with. Although the counsel in this room represent different participants and may be focussed on different aspects of the evidence, and naturally have different points of view, we are all working toward one goal, which is to understand what happened and to find ways to ensure that it doesn't repeat itself.

I would like to comment on the Inquiry experience itself.

OPENING REMARKS

We have said many times that this process is not an adversarial one and that our goal has been to gather information to learn and, where appropriate, to make recommendations. Although this is a fatality inquiry and not a public inquiry, we do on occasion reference Professor Ed Ratushny's book, **The Conduct of Public Inquiries in Canada**, and Professor Ratushny has pointed to some of the positive features of an inquiry, generally, and those include its independence, its effectiveness, and its transparency.

But an inquiry is not without its challenges. At the outset of this process, it was, frankly, difficult to know where to start, or at least it was for me. It was necessary to create the infrastructure of the Inquiry and that took time. Along with everyone in the world, we were faced with a pandemic in the midst of our proceedings and we had to pause and regroup. But we persevered and we were able to continue, and we are now at the point that we can make, I hope, positive recommendations for change.

SUBMISSIONS BY MR. MURRAY

(09:36)

Before speaking about the individual terms of reference, I would like to say something about the tragedy itself. As I said in my brief, the events of January 3rd, 2017 were a tragedy of unspeakable proportions that resulted in the loss of an entire family. In the case of Aaliyah Desmond, it was the loss of a child, a life's potential unrealized. In Shanna Desmond, it was the loss of a loving mother and wife. In Brenda Desmond, the loss of a caring and protective grandmother. And in Lionel Desmond, it was the loss of a husband, a son, and a brother.

Lionel Desmond lost his way. His actions were the product of a damaged psyche and a tortured soul. He committed acts that are impossible to understand, to explain, and really to comprehend. There are few words that properly capture the magnitude of the loss, the sheer horror of the events, and the pain suffered by those left behind.

It is human nature, perhaps, to try to find reason in chaos, to make sense of tragedy, to find the good, any good, in the worst of events. People who endure a tragedy such as this will often say that it must never happen to anyone else. An inquiry into the events of January 3rd, 2017 can try to help

people understand in some small way how the tragedy happened and attempt to find ways to prevent something like it from happening again.

The journey that led Lionel Desmond to the place he found himself on January 3rd, 2017 was long and complex. It is a story of missed opportunities. It is a story of information that was siloed and went unshared. It is a story of many caring professionals who wanted to help but, ultimately, could not. It is the story of the damage that can be inflicted by war on the soul of a man. It is a story of a regulatory scheme that allows the acquisition of firearms for those who can safely use them but which also attempts to protect society from those who cannot. And, ultimately, it is a story that involves violence in a family, a reality that is sadly all too common.

The job of this Inquiry is not to lay blame at the feet of anyone. It is not to point fingers. Rather, it is to understand, it is to learn, it is to look backward with the benefit of hindsight and see what might have been different so that it can be different in the future.

(09:40)

The February 14th, 2018 order that created this Inquiry presented us with a number of challenging questions and areas

for investigation. This is a fatality inquiry created under the provincial **Fatality Investigations Act**. It requires that Your Honour is to make and file with the Provincial Court a written report with findings you may make about a number of topics, including the date, time, place, cause, and manner of death of each of the deceased.

In this case, those questions are not really difficult. The date we know, of course, was January 3rd, 2017. And we know the place, the residence at 15375 Highway 16 in Upper Big Tracadie, Nova Scotia. The time we may not be able to know with exact precision but it is reasonable to put the time at approximately 6 o'clock p.m. based on various pieces of evidence, including a call between Chantel Desmond and Aaliyah Desmond before Chantel Desmond left New Glasgow, the time of a call from Brenda Desmond to her brother as the tragedy was happening and the calls to 911 when the tragedy was discovered.

The cause of death we learned from Medical Examiner, Dr. Erik Mont, is defined as "the disease or injury that in an unbroken chain ultimately leads to the person's death". In the case of each member of the Desmond Family, the cause of death was gunshot wounds. The manner of death, we learned, is a classification system comprised of five categories: homicide,

suicide, accident, natural, and undetermined. In the case of Shanna, Brenda and Aaliyah Desmond, it was homicide; and, in the case of Lionel Desmond, it was suicide.

Our order goes on to direct us to consider other areas and I will speak about those. They can be broadly grouped into those which reference mental health and access to mental health services, those that touch on domestic violence, intervention services, and those that deal with firearms. I'll address the mental health terms of reference first.

Your Honour, the death and complexity of Lionel Desmond's mental health challenges cannot be overstated. They were such that he needed consistent, structured, and comprehensive mental health services if he were to maintain any measure of stability and be able to function in his daily life. At times, those services were available to him; at other times, they were not.

Lionel Desmond, we know, was diagnosed with post-traumatic stress disorder and a major depressive disorder in 2011 while he was still serving in the Canadian Armed Forces. His healthcare journey brought Lionel Desmond to multiple healthcare providers and the Inquiry heard from many, if not most of those treating clinicians.

Between 2011 and the summer of 2016, he received treatment

in the Canadian Armed Forces after his release in New Brunswick at the Operational Stress Injury Clinic and, ultimately, at Ste. Anne's Hospital in Quebec, which provided the most intensive, structured, and multi-disciplinary treatment. Despite these various periods of intense treatment, his symptoms persisted.

His treatment in the Canadian Armed Forces, we learned, included work with psychologist, Dr. Wendy Rogers, who used the technique, prolonged exposure therapy, with Lionel Desmond. He received psychiatric and pharmaceutical treatment by psychiatrist, Dr. Vinod Joshi.

Despite some success in addressing his symptoms, those symptoms recurred and he continued to struggle underscoring the tenuous nature of his mental health.

Once released from the Canadian Armed Forces and while living in New Brunswick, he was treated by psychiatrist, Dr. Anthony Njoku and psychologist, Dr. Mathieu Murgatroyd.

In 2015, his treating psychiatrist, Dr. Njoku, stated bluntly that Lionel Desmond was still very severely suffering from his PTSD symptoms, which Dr. Njoku said hadn't really resolved or had, in fact, worsened after his release.

At the same time, the Inquiry heard evidence regarding the process of Lionel Desmond being assigned a case manager by

Veterans Affairs Canada, a process which, as I said, was also ongoing at this time. Although an initial work item was created in May of 2015 directing that Lionel Desmond be referred to a case manager to determine the need for case management or rehab support, he was not formally assigned a case manager until November 26th of 2015, and this was in spite of his desire to be assigned a case manager to assist with his transition and rehabilitation. The Veterans Affairs Canada running notes record multiple calls made by Lionel Desmond seeking assignment.

In the fall of 2015, after his release from the Canadian Armed Forces, was a period of flux for Lionel Desmond and there was uncertainty about where he would be living. Although it's difficult to say to what extent, the course of his treatment, and his need for continuous and structured care were impacted by the delays in the assignment of a VAC case manager. A timelier involvement would have engaged services in a more timely fashion.

Lionel Desmond was assigned a VAC case manager, Marie-Paule Doucette, in November of 2015. At that time, the Inquiry heard that Dr. Murgatroyd had called Ms. Doucette to express concerns regarding Lionel Desmond's instability and his need for continued and coordinated support. Ms. Doucette's first contact

with Lionel Desmond was on November 27th, 2015.

As evidence of Lionel Desmond's lack of stability at this time, it was on that same day, November 27th, 2015 that Shanna Desmond reported to police that she was receiving concerning texts from Lionel Desmond, which suggested he was contemplating suicide.

Lionel Desmond's treatment during this time culminated in his admission at Ste. Anne's Hospital in 2016. Here he worked with numerous healthcare providers from a wide array of disciplines. The level of engagement was comprehensive and continuous. The discharge summary from that hospital enumerated his many ongoing needs, including for a neuropsychological assessment and the need for assistance in his daily functioning, which may have been achieved with the assignment of a clinical care manager. These recommendations were designed to "ensure his continuity of care in the community".

To say there was a gap in his treatment upon his discharge from Ste. Anne's and his relocation to the Guysborough, Nova Scotia area would be an understatement. Lionel Desmond came to Nova Scotia with no services or treatment plan in place. Nothing was arranged for ongoing psychological counselling, medication compliance monitoring, social supports, or

neuropsychological testing.

Lionel Desmond's relationship with his wife was troubled and continued to deteriorate. For example, the Inquiry heard that Ste. Anne social worker, Kama Hamilton, had arranged a telephone call between the two during which the couple displayed significant frustration and anger with each other. Shanna Desmond expressed the concern that Lionel Desmond remained too volatile and angry and was concerned that he would be unable to regulate his moods. Nonetheless, Lionel Desmond returned to Guysborough, Nova Scotia, and resumed living with his wife and daughter. His mental health and the family dynamic continued to deteriorate.

Lionel Desmond was unable to access services at the naissant OSI or Operational Stress Injury Clinic in Nova Scotia. At the time of his relocation to Nova Scotia in 2016, the Nova Scotia Operational Stress Injury Clinic was still in its infancy. An inter-clinic referral was made to the Nova Scotia clinic by Dr. Murgatroyd on September 30th, 2016. The evidence the Inquiry heard left, frankly, some lack of clarity regarding the prerequisites for treatment in Nova Scotia at the time. Whether it was a formal policy or not, there was a requirement that any client of the clinic be established with a family

doctor prior to being seen by a psychiatrist. Lionel Desmond did not have a family doctor. Whether it was this requirement or the concern regarding travel from Guysborough to Dartmouth, he did not or was unable to avail himself of assistance from the clinic.

I would note that the Inquiry heard evidence from administrators and clinicians at the OSI clinic regarding its present structure and the services it provides. The Inquiry heard that the OSI clinic has grown and evolved since 2016 and is now able to provide more services than at the time of Lionel Desmond's brief interaction with staff at the clinic.

Lionel Desmond was, at best, an inaccurate historian of his own treatment history and when Lionel and Shanna attended at the Guysborough clinic and at St. Martha's Hospital, they had no medical records and physicians with whom they interacted had no way to access records.

(09:50)

For example, Lionel and Shanna Desmond attended at the Guysborough Medical Clinic on October 13th, 2016 and saw Dr. Luke Harnish. According to Dr. Harnish, Lionel was wondering about his follow-up plan after coming out of Ste. Anne's and "didn't know where else to turn".

SUBMISSIONS BY MR. MURRAY

Late in 2016, Lionel Desmond was referred by Dr. Ranjini Mahendrarajah to psychiatrist, Dr. Ian Slayter. He was seen by Dr. Slayter on December 2nd, 2016, and despite a really complete lack of access to medical records, Dr. Slayter was able to obtain a partial history and make a number of diagnoses. He stressed the need for an intensive treatment and rehabilitation program, intensive psychotherapy for Lionel Desmond's PTSD, and his jealousy regarding his wife, and for a neuropsychological assessment.

And in a conclusion that was both accurate and prescient, Dr. Slayter described Lionel Desmond as "falling through the cracks in terms of follow-up by military and veteran programs".

Lionel Desmond was eventually assigned a clinical care manager, Ms. Helen Boone, but she had difficulty navigating the VAC billing system, which delayed her work with him. Lionel Desmond was only able to meet with Ms. Boone for the first time on November 30th, 2016, approximately three months after his return to Nova Scotia.

When Lionel Desmond was finally established with a therapist in the community, a Ms. Cathrine Chambers, she too was left without medical records or helpful background information. Ms. Chambers was essentially starting at ground zero. She was

attempting to establish a therapeutic alliance with Lionel Desmond at a time when he should have been deeply engaged in therapy and treatment.

The lack of services in late 2016 resulted in what can only be described as a downward spiral in Lionel Desmond's mental health and stability. It is impossible to know if the outcome would have been different had Lionel Desmond been able to access services in Nova Scotia more quickly. But it is clear that he went from an intensive treatment environment at Ste. Anne's Hospital in Quebec to what was essentially a treatment void. Had more intensive and timely medical treatment been accessible when he returned to Nova Scotia, he may have been able to maintain some measure of stability and the outcome may have been very different.

Lionel Desmond's last attendance at St. Martha's Hospital came on the evening of January 1st, 2017 and into the early morning hours of January 2nd, 2017. After the tragedy, there was, unfortunately, some misunderstanding and confusion about the events surrounding Lionel Desmond's attendance at St. Martha's Hospital on the evening of January 1st and the early morning hours of January 2nd. For a period of time, there was a mistaken belief that Lionel Desmond had been turned away due to

a lack of capacity. This caused significant pain and frustration to his family. The Inquiry heard evidence from all members of the medical staff who treated and interacted with Lionel Desmond and who attended to his care. This included Dr. Justin Clark, who first saw him in the Emergency Department; Dr. Faisal Rahman, who was the on-call psychiatrist who treated him that evening; and multiple members of the nursing staff.

The staff that interacted with Lionel Desmond learned that he suffered from PTSD after having served in Afghanistan. They also learned that he had anger management issues, interpersonal conflicts with his wife, Shanna, and that he had shown violence to objects. This history was largely self-reported.

Dr. Rahman was of the view that Lionel Desmond did not meet the criteria for involuntary psychiatric admission but, rather, was allowed to stay in hospital as what was referred to as "a social admission". He was not turned away. He left the next day of his own accord and was advised to follow up with psychiatrist, Dr. Slayter.

But the interaction with hospital staff also revealed a number of significant domestic violence risk factors in his personal life. Lionel Desmond was suffering from the symptoms of PTSD and there was turmoil in his home. What, if anything,

could medical staff have done with this information? Shanna Desmond was not with Lionel Desmond that night. Had she been present, further interaction with her may have been possible. What might have been different if staff at St. Martha's Hospital had been able to more easily access at least a few of his earlier medical records including the Ste. Anne's discharge summary?

What the Inquiry has heard is that repeatedly professionals may not have fully grasped the numerous red flags for the risk of serious domestic violence or domestic homicide. Training in this area for all healthcare professionals may assist those professionals in recognizing those risk factors for domestic violence and giving them the necessary tools to act.

The access by clinicians to medical records has been a constant theme in these proceedings. The Ste. Anne's discharge summary did make its way to Lionel Desmond's VAC case manager. Had this summary made it into the hands of clinicians in Nova Scotia, the challenge they faced in treating Lionel Desmond might not have been any simpler but it would at least have been clearer.

The Inquiry heard that veterans leaving the Canadian Armed Forces or those who are accessing services paid for by VAC are

able to obtain their records in what may be described as the normal fashion, such as completing consent forms. Obtaining copies of medical records, a task that might seem manageable, albeit somewhat challenging for a healthy person, was all but impossible for Lionel Desmond given his poor mental health and the challenges in his daily functioning.

Could Veterans Affairs Canada play a role in supporting veterans in obtaining and organizing their medical records? The Inquiry heard evidence regarding the structure and function of Veterans Affairs Canada. Lee Marshall, the Director of Corporate Affairs for Field Operations, explained that VAC pays for health care but does not provide direct health care. He explained that VAC is not the holder of a veteran's health records.

While this Inquiry is limited in its ability to make recommendations related to federal government entities, there would certainly seem to be value in Veteran Affairs Canada and the Canadian Armed Forces being more proactive in ensuring that serving members and veterans are able to easily access their medical records and to be able to share them with local healthcare providers.

Presently, if a person comes to Nova Scotia and has in

their possession medical records from another province, they will need to provide them to a treating clinician or a medical records department at a hospital to be ingested, typically scanned or printed from another digital source and scanned. Even records held by healthcare providers within the province in different regions, we learned, and by private healthcare providers, are not easily accessible. The Inquiry learned that records are held in different electronic environments in different regions or zones with little ability to interface. According to Alyson Lamb, the Chief Nursing Informatics Officer, these systems are "several quite old, nonintegrated clinical systems".

The Inquiry learned that if records are brought to a medical facility to be ingested, such records would be categorized into an electronic category or a file or basket known as historical miscellaneous documents or external documents correspondence and this is true of any of the electronic records keeping systems or environments in the province.

The Inquiry was told that technically an electronic subcategory could be created in the medical records systems that currently exist that could contain medical information related

to a veteran relocating to Nova Scotia from another province.

Additionally, the Inquiry heard this is also something that could theoretically be done in the new One Person-One Record environment. As a possible recommendation, the Nova Scotia Health Authority should designate a person as a navigator to assist veterans who are being released from the Canadian Armed Forces or who are relocating to the province in obtaining their medical records and having those records ingested into electronic medical records in this province for easier assess by Nova Scotia clinicians.

Additionally, any electronic recordkeeping system maintained and utilized by the Nova Scotia Health Authority should have a specific category for records provided by a veteran of the Canadian Armed Forces relocating to Nova Scotia or from another province. This should also apply to the new One Person-One Record environment when that is implemented.

One consistent recommendation that recurs in the reports and treatment plans of many of Lionel Desmond's treating professionals was the need for a neuropsychological assessment. He was never given one, despite numerous clinicians expressing the opinion that it would have been beneficial in assessing any of his cognitive deficits.

Witnesses at the Inquiry expressed different opinions regarding the availability and wait times for such assessments in Nova Scotia. As a possible recommendation, the Nova Scotia Health Authority and the Nova Scotia Department of Health and Wellness should assess the availability of neuropsychological assessments in the province and, if needed, take steps to ensure they are more readily available.

(10:00)

The Inquiry heard evidence about the manner in which mental health clinicians assess suicide risk. The Nova Scotia Health Authority Mental Health and Addictions Policy and Procedure entitled **"Suicide Risk Assessment, Intervention Monitoring and Management for Mental Health and Addictions"** was made an exhibit at the Inquiry. That policy contains a suicide risk assessment and intervention tool. Dr. Rahman, in his evidence, described the implementation of this instrument and the training of staff on it.

Other suicide risk assessment tools and instruments are used. Dr. Slayter and Mental Health nurse, Heather Wheaton, completed and referred to an earlier version of that tool which was embedded in the Crisis Response Service Mental Health Risk Assessment document. Nancy MacDonald from Family Services of

Eastern Nova Scotia testified that that organization utilizes a suicide risk assessment tool which is based on other evidence-based risk assessment tools.

Dr. Scott Theriault testified that while it is impossible to predict whether any individual at a point in time will commit suicide, suicide risk assessment tools assist in creating risk management plans. They allow for a safety net, he said, that could be utilized when individuals go through periods of acute crisis where their suicide risk may be elevated. There appears to be value in the use of an evidence-based suicide risk assessment tool for mental health clinicians. Ongoing training in this area for staff engaged in mental health is also essential.

As a possible recommendation, the Nova Scotia Health Authority should continue to update its suicide risk assessment tool and policy based on the most up-to-date evidence on suicide risk assessment and continue to train staff engaged in mental health on the policy and the tool.

One issue explored by the Inquiry focused on the unique needs of the African Nova Scotian community as they navigate the healthcare system and seek mental healthcare services. The Inquiry heard from four witnesses who testified under the

umbrella of Health Association of African Canadians. The Inquiry heard that there is a "lack of culturally specific mental health and domestic violence services in Nova Scotia" and that there is "an inability to access informed and culturally specific health resources and culturally competent care".

The witnesses who testified under the umbrella of HAAC pointed to an overall mistrust of the healthcare system in the black community. They made a number of recommendations, some of which I will repeat here. The Nova Scotia Department of Health and Wellness and the Nova Scotia Health Authority should partner with appropriate community organizations to provide more comprehensive virtual care to rural African Nova Scotian communities.

The Nova Scotia Department of Health and Wellness and the Nova Scotia Health Authority should take steps to recruit black and diverse mental health providers to provide culturally-informed and responsive care with an emphasis on training in the areas of psychosocial services, occupational stress, and general mental health and addictions.

And the Nova Scotia Department of Health and Wellness and the Nova Scotia Health Authority should recruit and provide education scholarships for black registered nurses and nurse

practitioners.

On January 3rd, 2017, Lionel Desmond contacted Family Services of Eastern Nova Scotia to change an upcoming appointment for couples counseling to individual counseling. He had originally been encouraged to contact Family Services by his clinical care manager. Obviously, Lionel Desmond was never able to attend this appointment. However, the Inquiry heard about the work done at Family Services, in general, and through its Men's Health Centre. The Executive Director, Ms. Nancy MacDonald, also testified and described the new 24-hour men's help line operated by Family Services which is available through the provincial 2-1-1 system, which launched in September of 2020.

Ms. MacDonald described the system as a free, confidential service for men who are experiencing concerns about their well-being or who are under stress. The caller will, she said, reach an individual who will assist them in navigating referrals and provide brief intervention counseling. Were this service to have been available to Lionel Desmond, it could have provided an opportunity for further engagement and assistance in navigating access points for his continued treatment.

So as a possible recommendation, the Province of Nova

Scotia should ensure that funding for the men's help line through the provincial 2-1-1 system continue and work to increase public awareness of this service.

Another general area that our terms of reference direct us to is that of domestic violence intervention services. The Desmond tragedy, Your Honour, can be described in many ways as many things. Clinically, Dr. Scott Theriault said that the tragedy best fit the profile of "a homicide/suicide of the familicide-suicide type". Ultimately, it was the most extreme manifestation of family violence imaginable.

Lionel Desmond's diagnosis of PTSD was well established and known to his healthcare providers from 2011 onward. There were, however, many issues with which Lionel Desmond struggled and they did not exist in watertight compartments. His occupational stress injury, PTSD, was only part of his complex clinical and personal presentation. While those who dealt with him and treated him understood his PTSD diagnosis, they did not always see or understand that his family life was deteriorating and was becoming dangerous.

Lionel Desmond harboured an increasing suspicion of and, at times, resentment toward his wife. As he struggled with his symptoms and the lack of direction in his life, Shanna Desmond

was embarking on a new career as a registered nurse. She was becoming exhausted dealing with his mood swings and outbursts and the couple appeared to be nearing a separation.

The lack of clarity in his thought process left Lionel Desmond with suspicions of his wife's fidelity that, while not frank delusions in the opinion of Dr. Slayter, were certainly overvalued and without basis. At times, he could understand that the suspicions about his wife were baseless; at other times, he could not.

The Inquiry heard evidence from Dr. Peter Jaffe, one of the country's preeminent experts in the area of domestic violence. Dr. Jaffe had the opportunity to review much of the relevant evidence called by the Inquiry. In his testimony and in the report he prepared for the Inquiry, Dr. Jaffe stated frankly,

> The January 2017 triple homicides and suicide committed by Cpl. Desmond that took the lives of his wife Shanna, their 10-year-old daughter Aaliyah, and his mother Brenda, seem entirely predictable and preventable, with hindsight. This hindsight is clear in the context of all the information available about the serious risks that Cpl. Desmond

was presenting and the history that could have been known to professionals as well as family and friends. Although it may have been difficult to predict exactly when and how these events would unfold, Cpl. Desmond and his family seemed on a clear path for a horrific tragedy based upon all available information reviewed by the Inquiry.

Of the 41 risk factors associated with domestic homicide utilized by the Ontario Domestic Violence Death Review Committee, Lionel Desmond presented with 20, according to Dr. Jaffe. Among them were some of the risk factors seen with most frequency in domestic homicides. They included a history of domestic violence, a pending separation, the perpetrator suffering from depression, and prior threats by the perpetrator to commit suicide.

Dr. Jaffe noted that Lionel Desmond interacted with a multitude of professionals, as many as 40 medical practitioners, mental health professionals, and police who had exposure to aspects of the stressful circumstances and accumulating risks that Cpl. Desmond was presenting. However, each professional seemed to assess the risks that Lionel Desmond presented in

isolation.

One of the most troubling aspects of the history of Lionel Desmond's treatment was the lack of understanding that domestic violence was very much present in the Desmond relationship and that it posed a real and objectively measurable increased risk of harm. Dr. Jaffe noted in his report that frontline professionals may have lacked awareness or training about domestic violence warning signs.

Based on his review of Inquiry evidence, Dr. Jaffe stated that, "From 2011 to 2017, no one really addressed the extent of domestic violence and abuse". Rather, Dr. Jaffe states that, "Multiple euphemisms were used to describe the marital issues". This, he said, was a function of several common misunderstandings about domestic violence that were exhibited by the professionals and service systems involved with the Desmond family. He stated, at page 22 of his report,

> In my file review (he said) I found several common misunderstandings about domestic violence that were exhibited by the professionals and service systems involved with the Desmond family. In my opinion, these misunderstandings undermined the

> potential for better assessments of the serious risk and appropriate interventions required. The terms 'violence' and 'abuse' were rarely used or expanded upon in interviews with both Lionel and Shanna Desmond. The problem was not named. There was a focus on mental health alone and not the impact of Cpl. Desmond's suicidal behaviour and other symptoms on his wife and daughter. His suicidality was a potential risk for both himself and for others in his life and there needed to be more done to manage the risk to all involved.

(10:10)

Additionally, Dr. Jaffe noted that Shanna Desmond's perspective was rarely sought by professionals, that when the topic of abuse was approached, it was focused on physical abuse rather than recognizing the multiple forms of domestic violence and that Lionel Desmond's presenting problems were seen as either mental health or domestic violence but not both. Dr. Jaffe noted that none of the professionals involved considered the need for specialized domestic violence program for abusers

as a complement to other treatments.

Shanna Desmond, herself, appears to have only begun to comprehend the danger that she and her child were in near the end of her life. Her first and only call to the Naomi Society in Antigonish, a not-for-profit organization providing services to women and children who have experienced intimate partner violence in the Antigonish/Guysborough area was on the afternoon of January 3rd, 2017. According to the notes made by Executive Director Nicole Mann with whom she spoke, Shanna Desmond requested and received information but was not yet ready to make an appointment.

Dr. Jaffe felt that Shanna Desmond was trying to manage a difficult situation without enough external resources and that, "like half of homicide victims, she may have seen the danger her husband presented to himself but not to herself or her family".

Several of the medical and mental health professionals who testified at the Inquiry acknowledged that they would benefit from additional training or continuing education in the area of domestic violence; for example, Drs. Slayter and Rahman both said this. This is an area in which Dr. Jaffe made recommendations specifically that professional education on domestic violence and domestic homicide be expanded. He listed

the elements of this professional education and training.

Additionally, Dr. Jaffe recommends that the Schools of Social Work, Psychology, and Medicine need to ensure courses are provided on domestic violence and risk assessment and management, and that the regulating bodies and professional associations for these professional groups provide ongoing professional development on domestic violence.

One of his recommendations, which I will repeat here, is that we need to ensure that frontline professionals in multiple systems such as health, mental health, education, social services, and justice are up-to-date with current information about domestic violence, the dynamics in these relationships, the impact of domestic violence on children, and potential for lethality in these cases. This should include an awareness of risk factors, risk assessment, safety planning, and risk management strategies.

One of the entry points for families to access domestic violence intervention services can occur when police are called. The Inquiry heard evidence that police agencies interacted with the Desmond family on several occasions. Police were called for wellness checks on Lionel Desmond regarding his expressions of suicidal ideation, his anger, and once because Lionel Desmond,

himself, believed that Shanna Desmond had left and was ending their marriage.

None of these interactions resulted in criminal charges under the **Criminal Code of Canada**. Indeed, there was nothing reported to police that necessarily should have resulted in criminal charges. And, yet, in retrospect, each of these interactions were replete with warning signs about the risks of domestic violence and domestic homicide.

The Inquiry received information regarding the training police in this province receive when they are called upon to deal with calls of a domestic nature where intimate partner violence may be occurring. The Inquiry heard evidence from Sharon Flanagan, Senior Lead, Policy and Public Safety Division in the Department of Justice.

Regarding the use of domestic violence risk assessment instruments, Ms. Flanagan testified that all police agencies in the Province of Nova Scotia employ the Ontario Domestic Assault Risk Assessment, or ODARA, to assess risk in domestic violence cases. This is a consistent policy, she said, employed by all police agencies; however, it is not mandated by a policing standard. In fact, there is no policing standard in Nova Scotia regarding investigations of intimate partner violence or the use

of domestic violence risk assessment tools.

The ODARA is a tool, she said, that was designed to predict the risk of recidivism in cases of domestic assault. The importance of a domestic violence risk assessment tool was underscored by Dr. Jaffe in his testimony. The Inquiry heard that multiple domestic violence risk assessment tools are available, such as the ODARA, the Jacquelyn Campbell Danger Assessment, and the Domestic Violence Risk and Management Report, or DVRM, which is the tool used throughout Ontario.

The appropriateness of a particular instrument can depend on the context The uniform and consistent use of a domestic violence risk assessment tool by police in cases of a domestic nature that do not ultimately result in criminal charges but where concerning behaviour related to an intimate partner is present would have value. This would provide for the opportunity to identify risk factors and engage with a domestic partner who may benefit from a warm handoff to another agency or to the Victim Services Domestic Violence coordinators who work with various police agencies. A comprehensive domestic risk assessment tool such as the DVRM report used in Ontario, which incorporates the ODARA instrument, may be particularly well suited.

As possible recommendation, Nova Scotia should institute a policing standard requiring all police agencies to utilize a domestic violence risk assessment tool such as the DVRM in all calls and investigations involving domestic conflict where concerning behaviour regarding an intimate partner is present irrespective of the existence of the criminal charge.

In his report to the Inquiry, Dr. Jaffe also referenced the Nova Scotia High Risk Case Coordination Protocol and expressed the opinion that there missed opportunities to use this protocol. He felt the Desmond family situation represented a high-risk case that needed to be flagged and enhanced coordination efforts were required among police, victim services, social services, mental health, and healthcare professionals.

As a recommendation, the Nova Scotia Departments of Justice and Community Services review the high-risk case coordination protocol to deal with cases in which there is no criminal offence but there is concerning behaviour related to an intimate partner.

The third general area that our terms of reference point us to is the Nova Scotia Administration of the Canadian Firearms Program and whether Lionel Desmond should have been able to

retain or obtain a license enabling him to purchase or obtain a firearm.

Your Honour, we learned that Lionel Desmond purchased a Simonov SKS 7.62 semi-automatic rifle, a non-restricted firearm, on the afternoon of January 3rd, 2017. He did so lawfully. The vendor that sold him that gun acted appropriately on that day given what he knew. Lionel Desmond had a valid possession and acquisition license to purchase the firearm and ammunition. He had applied for that license and followed the necessary and applicable procedures required of him.

The firearm he used on January 3rd, 2017 was not purchased illegally on the street. It was purchased lawfully from a reputable sporting goods store. And, yet, he clearly should not have had a gun. The grave state of his mental health and the deterioration of his marriage and home life created a situation where he was a danger to himself and to others with a gun.

So the question remains, If all of the appropriate legal steps in acquiring the license were taken, what could have been done differently? What information might have led decision-makers who were tasked with deciding whether to issue Lionel Desmond a firearms license to take a different course? What safeguards might have allowed a firearms officer to know that

there was a danger in Lionel Desmond having a gun? What can change to assist those who are given the task of determining if it is safe for a citizen to have a license that permits them to purchase a firearm?

In my written submissions, Your Honour, I've reviewed the history of Lionel Desmond's interaction with the Office of the Chief Firearms Officer in New Brunswick. I won't review all of that but, of significance, on two occasions Lionel Desmond was provided with medical forms for completion by physicians as a result of concerns about his mental health.

Where an applicant initially applies for a firearms license or applies to renew an existing license, the Inquiry has heard that an applicant may be asked to provide a consent to the Office of the CFO to obtain medical information about the applicant. This can result from various concerns. For example, the application for a possession and acquisition license under the **Firearms Act** asks the applicant if they have threatened or attempted suicide in the past five years, if they suffered or had been diagnosed or treated my a medical practitioner for depression, alcohol, drug, or substance abuse, behavioural problems or emotional problems.

(10:20)

SUBMISSIONS BY MR. MURRAY

This question is meant to give effect to one of the eligibility requirements found in the **Firearms Act** of Canada. Should an applicant answer "yes" to this question, they may be required to submit a completed Form 6423, or Consent for Disclosure of Medical Information to a Chief Firearms Officer. This form was exhibited and it is comprehensive in that it requires information from the applicant's medical practitioner regarding their current health condition; their prescribed medication, treatment, and counseling; the effects of their medication; their compliance with treatment, and the doctor's opinion regarding the consequences of failing to comply with their pharmaceutical regime.

While this information is helpful in assisting a firearms officer in making their decision regarding licensing, it is nonetheless information regarding the applicant's status at one point in time only. On two occasions, doctors provided opinions that Lionel Desmond's health was such that, in their opinion, he could possess a firearm. This was once by Dr. Joshi in December of 2014 and subsequently by Dr. Paul Smith in February of 2015. Both of these opinions were, of course, snapshots in time. They were a reflection of the respective physician's opinions of Lionel Desmond's mental health at the moment that those forms

were completed, or at least when he was last seen.

But what of the future? A firearms license is typically granted for a five-year period. An applicant who is granted a license is subject to continuous eligibility screening throughout that period, which begs the question, What if during that period a stable person becomes unstable? What if a person who is compliant with respect to their prescribed medications becomes non-compliant? What if an individual who is maintaining a tenuous grasp on good mental health and daily functioning experiences a significant and stressful negative life event? Would a clinician who completes a form, as Drs. Joshi and Smith did, still maintain that same opinion?

No clinician can predict the future with certainty. None could be expected to do so. But the question remains how a government entity determines if a person should continue to be able to lawfully possess a firearm during the period of their license. Lionel Desmond left the Canadian Armed Forces and moved through different treating clinicians. His mental health was not consistent during this time. The Lionel Desmond of 2014 was not the Lionel Desmond of 2016. As the Inquiry heard repeatedly, Lionel Desmond's mental health and stability was a moving target during this time.

Once a possession/acquisition license has been issued, the only way in which that license can come under further scrutiny by the Office of the CFO is if information of concern comes to the attention of the Office of the CFO; in most cases, through a firearms interest police. However, as was evidenced in the case of Lionel Desmond, not every interaction with police or a police agency will result in a firearms interest police being generated. If a license is granted, the facilitation of timely information coming into the hands of a CFO regarding changes to the health status of a client license holder may be crucial to the work of that office in assessing continuing eligibility.

An argument can be made that a document in the form of an enduring authorization and consent or direction which would allow a CFO, or Chief Firearms Officer, to periodically request medical information during the period of the license and which would require the treating physician to report changes in the client's health status could assist with this.

When asked if there would be value in "medical practitioners advising firearms officers of a change in the mental health circumstances of their patients or that client are no longer a patient during the five-year period that the firearms license is valid", Mr. John Parkin, Nova Scotia Chief

Firearms Officer, answered affirmatively. When asked what the value would be, he said,

> The value is that we rely on external sources to provide us with a lot of the, for lack of a better word, alerts when an individual is experiencing crisis, or when there are difficulties, to bring it to our attention. For example, there is more than 75,000 license holders in Nova Scotia at the present time. We have a staff of nine people effectively to monitor those individuals for any signs of distress or anything else that's going on. So we rely upon external sources of information to come to us and let us know that there is the possibility of public safety risk or an individual who is at risk.

So as a possible recommendation, Your Honour, an applicant for a firearms license or a renewal of a firearms license should be required to give an enduring consent and direction to the Office of the Chief Firearms Officer to allow for followup with a medical practitioner at any time during the period that the

license is valid and in effect, and to require the medical practitioner to report changes in the health status of the applicant.

Additionally, Your Honour, the Chief Firearms Office should, in appropriate cases, place certain licenses under review and seek additional medical information if necessary to ensure that applicants who have been granted licenses are continuing to meet eligibility requirements and are maintaining good mental health.

And, finally, as another recommendation, the Office of the Chief Firearms Officer should receive additional funding to facilitate additional and ongoing checks of the mental health status of licensees.

Lionel Desmond had interactions with the police during this time. The Inquiry heard evidence regarding a concept I mentioned a moment ago, a firearm interest police or, commonly, a FIP. Creation of a FIP, we learned, is a function of several factors. Each time a police agency investigates or is called to an event, it is coded using a uniform crime reporting, or UCR code.

In Canada, these are ingested into the Canadian Police Information Centre database or CPIC. That database, in turn,

communicates with the Canadian Firearms Information System or CFIS. Depending on the nature of the code used by an investigating agency, a FIP will be created and this will ultimately make its way to the CFO for the applicable province. The CFO will then investigate to determine if the person who is the subject of the FIP, first of all, is a client, a license holder, and if so will determine how to proceed further. During the period that the FIP is investigated, the person's license may be placed under administrative review.

The Inquiry learned that such a FIP was created on November 18th, 2015 when S/Sgt. Addie Maccallum responded to a request for a wellness check on Lionel Desmond in Guysborough initiated by a call from Shanna Desmond. The CFO's office in New Brunswick was not initially aware of this FIP and only became aware of it as a result of a subsequent event later in that month.

Indeed, in her evidence to the Inquiry, Acting New Brunswick Chief Firearms Officer Lysa Rossignol testified that the FIP from the Nova Scotia event would not have come to their attention but for the fact that a subsequent event created a second FIP. That second FIP was created as a result of the RCMP response to a request for a wellness check on Lionel Desmond on

November 27th, 2015.

This request resulted from Shanna Desmond receiving text messages from Lionel Desmond that strongly suggested he was contemplating suicide. The FIP associated with this event was received by the CFO office in New Brunswick which placed Lionel Desmond's license under review and assigned Firearms Officer Joe Roper to investigate.

Officer Roper commenced his investigation by forwarding a letter to Lionel Desmond seeking completion of the Medical Assessment by Physician Form. The information relating to the November 18th, 2015 incident was not provided on the form as it had not yet been received by the New Brunswick CFO office.

That form was ultimately completed, as we know, by Dr. Paul Smith and returned to the CFO office on February 29th, 2016. Would Dr. Smith's opinion that Lionel Desmond was non-suicidal and stable, and his experience that he had no concerns for firearms usage with an appropriate license have been different had he had more information?

While this process was ongoing, the New Brunswick CFO office was also seeking disclosure from the RCMP regarding the November 18th incident. This disclosure was not received by New Brunswick until April 14th, 2016. The New Brunswick CFO was

dependent on receiving this information indirectly from another province.

As a possible recommendation, Your Honour, Chief Firearms Officers should work to ensure that processes are in place to notify other provinces when clients of those other provinces are involved in events that create FIPs in the CFO's province and to ensure that the information is shared in a timely manner.

On November 28th, 2015, Lionel Desmond returned from Oromocto to Nova Scotia and was described as upset and yelling about the fact that his firearms had been seized for safekeeping. Police attended, but no FIP was created as a result of this incident. Fully a year later on November 25th, 2016, RCMP in Guysborough were dispatched to a call received from Lionel Desmond wherein he expressed concern that his wife Shanna was overdue. He later told police that she had been located but that "she was kicking him out and their marriage was over". Despite the known history and RCMP involvement, this incident did not generate a FIP.

(10:30)

Naturally, Your Honour, not every police event can or should create a FIP. Nonetheless, had some of these events been coded in a way that did create a FIP, they would have provided

important information to the CFO for consideration. UCR and FIP coding is, therefore, an important part of that.

As a possible recommendation, Your Honour, police officers in Nova Scotia should receive additional training on proper UCR and FIP coding.

When a FIP is created and an investigation commenced, CFOs must have access to accurate and timely information about police incidents. Access by the Office of the CFO to police databases was an issue about which the Inquiry heard evidence. This can best be described as a work in progress.

According to the Nova Scotia CFO, his office has made some progress in obtaining greater access to the RCMP police reporting and occurrence system, or PROS. Previously, a form had to be used. And in New Brunswick, for a time, an officer was actually tasked with summarizing a police occurrence report and providing this to the CFO. With respect to the databases used by other police agencies, firearms officers often need to rely on relationships they may have with those police agencies. Better access to this information would allow for a speedier and more comprehensive investigation of a firearms interest police and other firearms issues.

As a possible recommendation, Your Honour, all steps

necessary should be taken to expedite access by Chief Firearms Officers to various police databases, including PROS; Versadex, used by the Halifax Regional Police, and; Niche, used by the Cape Breton Regional Police.

Your Honour, on January 3rd, 2017, Lionel Desmond attended at Leaves & Limbs and purchased the firearm that he would ultimately use to kill his family and himself. The store owner, Daniel Kulanek, asked for and was shown Lionel Desmond's license. It appeared to be valid. It was valid. He ensured that the PAL was not expired and that the person depicted on the license was the person before him, which was required by law. Although not required, he also recorded the license number and expiry date on the PAL which he cross-referenced to the serial number of the gun sold.

The provisions of **Bill C-71**, which require a firearm vendor to check the status of a PAL, have not yet come into force. The vendor was not required, in this case, to check the status of Lionel Desmond's license. In this case, had he done so, that call would not have indicated any reason to refuse to sell the gun. That said, the requirement for vendors to conduct such a brief check could have significant public safety benefits.

As a possible recommendation, the Province of Nova Scotia

should encourage the federal government to proclaim, enforce the provisions of **Bill C-71**, requiring vendors to check the status of possession and acquisition licenses prior to selling a firearm.

Your Honour, in conclusion, Dr. Jaffe noted that one of the shortcomings with any Inquiry is that when the public attention is gone from here, the impetus for change may diminish over time. He also states that recommendations flowing from any Inquiry such as this will not happen overnight and require extensive collaboration across different government departments. He recommends the creation of a formal implementation committee with a minimum five-year mandate to do this work.

So as a final recommendation, the Province should, to ensure that the recommendations from this Inquiry are not lost with the passage of time, the government should create a formal implementation committee made up of senior government officials from different departments to oversee the implementation of the Inquiry's recommendations. This committee should have a minimum five-year mandate and involve liaison with appropriate federal government departments.

Your Honour, those are my submissions, subject to any questions or comments you may have.

SUBMISSIONS BY MR. MURRAY

THE COURT: Thank you, Mr. Murray. I don't have any comments. Thank you very much for your thoughtful consideration of the subject matter.

Counsel, we'll take a break, about 15 minutes. So we'll come back at maybe 10 to 11, thereabouts. All right. Thank you.

COURT RECESSED (10:35 HRS)

COURT RESUMED (10:53 HRS)

THE COURT: Ms. Ward?

SUBMISSIONS BY MS. WARD

MS. WARD: Thank you, Your Honour.

Together with my colleague, Melissa Grant, I make these submissions on behalf of the Attorney General of Canada. Before I begin, I want to echo Mr. Murray and thank participants' counsel, Inquiry counsel, and Your Honour for the collegiality and professionalism displayed without which this process would've been much more difficult.

"Tragedy" is a word we've used repeatedly during this Inquiry to describe the events that brought us here, and, somehow, it doesn't seem adequate to describe the deaths of Shanna, Brenda, Aaliyah, and Lionel Desmond. The Borden family and the Desmond family will never be the same. Perhaps no word is adequate.

The story of retired Cpl. Lionel Desmond is complex. He was, by all accounts, quick with a joke and quick to lend a hand. Although he was repeatedly described as happy-go-lucky, he nonetheless described suffering abuse in childhood, he was subjected to racism, accounts of his relative success in school varied, and one of his best friends described some difficulty grasping his military training.

Lionel Desmond saw horrific things in Afghanistan and no one denies that he developed post-traumatic stress disorder as a result of his tour. Although PTSD is complicated and perhaps not yet completely understood, there is no denying it is a hazard of war. Some of the things we heard about PTSD: There are a lot more people in the general population with PTSD than the average person thinks there are. There is often a delay before a person seeks treatment. Some people make great progress in treatment and some don't. And most people with PTSD are not violent.

It was sometime after returning from Afghanistan that Mr. Desmond sought help. We heard that this was not uncommon and that it is very hard to predict how different people react to stressors. It is also common for someone to seek treatment at the urging of their spouse as Mr. Desmond did. While he was still a member of the Canadian Armed Forces, or "CAF", Mr. Desmond was in the care of the Operational Trauma and Stress Support Centre, or "OTSSC", at Canadian Forces Base Gagetown, New Brunswick. The OTSSC is a multidisciplinary treatment centre where a patient has access to psychiatrists, psychologists, social workers, addictions counsellors, and mental health nurses. A patient could also self-refer for

addictions or couples counselling.

Lionel Desmond was treated by psychiatrist, Dr. Vinod Joshi, and psychologist, Dr. Wendy Rogers, both of whom had extensive experience treating PTSD and depression in the military population. We heard that the gold standard treatments for PTSD involve psychotherapy, such as prolonged exposure therapy, or "PET", or cognitive processing therapy, "CPT", but that medications could help with symptoms while a patient was engaged in therapy. Dr. Joshi prescribed medication for depression, anger, and mood swings, sleep and nightmares from PTSD. Dr. Rogers used PET and CPT to treat Mr. Desmond's PTSD. At this time, Mr. Desmond had not reported any head trauma and did not show signs of unusual cognitive impairment. On that issue, Dr. Rogers said she "just did not see any signs of impairment in him". She said:

> CPT might be more of a challenge because if somebody had cognitive difficulties, you would notice in things like their ability to organize things; their memory; whether or not they were coherent; whether they complained of, say, recurrent headaches and had to see their medical officer about it.

SUBMISSIONS BY MS. WARD

But none of those things happened. He was very capable of organizing things. Like when his daughter lived with him, there was no issues. He was always coherent. He could remember things. He described things clearly. Like I had no evidence that he had cognitive difficulties other than the typical mild ones that people get when they're depressed. When people are depressed, they often ruminate and their concentration is poor.

Throughout his treatment of Lionel Desmond, Dr. Joshi never observed psychosis or paranoia. Lionel Desmond's fears were not unfounded or unrealistic. He was worried that his wife might leave him but he was not delusional or psychotic in nature.

Over time, Lionel Desmond made gains while in Dr. Rogers' and Dr. Joshi's care and his psychological triggers seemed to shift from his time in Afghanistan to ongoing marital strife. All the clinicians canvassed in this Inquiry stated that they would've welcomed the involvement of a patient's spouse or family but that this had to be the patient's choice.

(11:00)

Unfortunately, this was a time when Mr. Desmond was living in Oromocto, New Brunswick, and his wife, Shanna, was living in Nova Scotia. When Lionel Desmond released from the Canadian Armed Forces in July 2015, it was at that point that he had access to benefits and services through Veterans Affairs Canada, which I may refer to as "VAC". VAC's then Acting Director of Corporate Affairs for Field Operations, Mr. Marshall, testified at this Inquiry for an entire day about the programs and services available to veterans. He talked about the transition process from CAF to VAC; transition interviews, assessments, the role of case managers, and financial benefits. What became apparent was that there is an array of programs and services available to veterans that is extensive and comprehensive and which includes financial benefits, health benefits, rehabilitation, and vocational benefits; and, yes, case management. What also became apparent, or should have become apparent, is that Veterans Affairs is not a healthcare provider. VAC reimburses the costs of healthcare services for eligible veterans. Neither is VAC a custodian of medical records.

Lionel Desmond was approved for a disability benefit based on his PTSD and was, therefore, eligible for healthcare services like psychotherapy, massage therapy, and prescription

medications. After his release, Mr. Desmond had a relatively seamless transition to the Operational Stress Injury Clinic in Fredericton and entered the care of Dr. Njoku, a psychiatrist, and Dr. Murgatroyd, a psychologist. Like the OTSSC, the OSI Clinic is a multidisciplinary clinic where clients have access to multi-faceted treatment. The OSI Clinic is a top-of-the-line care facility funded by Veterans Affairs where Mr. Desmond had access to the same gold standard treatments that were available to him while he was in the CAF. Access to an OSI clinic is limited to CAF and RCMP veterans.

Lionel Desmond was also recommended for case management and was assigned to case manager, Marie-Paule Doucette, in November of 2015. Was there some delay in getting a case manager? Yes. It took some months. VAC was in the process of hiring more case managers after previous budget cuts, but soon after she was assigned to Mr. Desmond, his care team at the OSI Clinic contacted her and advised that they thought an inpatient stay at the OSI Clinic at Sainte-Anne-de-Bellevue in Montreal would be beneficial. Ms. Doucette hit the ground running. She met with Mr. Desmond in December 2015 at his home in Oromocto to begin an intake assessment. They met again in January 2016. Ms. Doucette finished her assessment, created a rehab plan, and they

began to discuss the recommendation for inpatient treatment. At this time, Mr. Desmond's preoccupations, shared with his caregivers and case manager, centered around his marital struggles.

Ms. Doucette consulted the VAC Regional Mental Health Officer and the admission nurse at Ste. Anne to get the necessary approvals for inpatient treatment in place, and Mr. Desmond was accepted into the program, but he and Ms. Doucette were told to expect a four to six-week delay. Ms. Doucette liaised with Ste. Anne on an ongoing basis beginning in February 2016. After four weeks, Mr. Desmond grew impatient. He was still in the care of the OSI Clinic and Ms. Doucette encouraged him to stay focussed. He was concerned about his ability to pay upfront for his travel to Montreal, so Ms. Doucette looked into getting prepayment approved by VAC, which was not the norm. They maintained three-way contact with the admissions nurse at Ste. Anne through March 2016.

At this point, Mr. Desmond wavered a bit. He had a lot going on. He was trying to sell his house and he wanted to move back to Guysborough County to be with his wife, Shanna, and daughter, Aaliyah, and Mrs. Desmond was graduating from nursing school during this period.

SUBMISSIONS BY MS. WARD

In April 2016, he advised that he wanted to postpone inpatient treatment until August. The contract with the relocation people to sell his house was going to expire, the house had not sold, and it was stressing him out. Ms. Doucette offered to help him sort it out. He politely declined. Ms. Doucette had a home visit with Mr. Desmond. He had been spending a lot of time in Nova Scotia. He talked about his marital and financial pressures. He believed Mrs. Desmond had divorce papers that she would bring up jokingly. Ms. Doucette tried to help Mr. Desmond problem solve. She helped him with the relocation company and he left a voicemail. He continued to be treated by the OSI Clinic both in person and on the phone.

In May of 2016, Mr. Desmond changed his mind and wanted to go to Ste. Anne sooner. Ms. Doucette helped him fill out the detailed paperwork, helped him jump through the necessary hoops to get exceptional prepayment with his travel expenses. She rearranged his last psychiatry appointment at the OSI Clinic because it fell on his travel date. She drove him to the airport. She saw him through security and he was admitted to Ste. Anne on May 30th, 2016.

Once again, Mr. Desmond had access to a multidisciplinary team that included a psychiatrist, Dr. Ouellette; a

psychologist, Dr. Gagnon; a social worker, Ms. Hamilton; as well as mental health nurses, an art therapist, and yoga teacher. The Ste. Anne program was a two-phase program with a stabilization phase followed by a treatment phase. Unfortunately, it seems that inpatient treatment was not optimal for him as he seemed to find group therapy difficult and it was noisy, a similar complaint he had had growing up in a crowded multigenerational home.

Lionel Desmond did not reach the stabilization phase and decided to leave the program early. Dr. Gagnon said:

> But when we think about kind of an overarching framework in terms of treating post-traumatic stress disorder, often there's this thought that we can break it down in three different categories; the first category being kind of a stabilization phase where you develop a lot of these skills so that you then have the internal and external resources to do the more trauma-focussed work. And some people never get there.

What is clear is that Lionel Desmond had access to the best

care at this time. Dr. Gagnon and other clinicians told us, though, access to treatment does not necessarily ensure success or even progress.

As we all know, it was after Mr. Desmond left Ste. Anne in mid-August that it became more difficult to coordinate his care. Several professionals testified that it was highly unusual that someone leaving inpatient care would not be returning to their referring team; in this case, the team at the OSI Clinic in Fredericton.

However, the house was sold and at that point, Mr. Desmond was bound and determined to return to Nova Scotia to be with his wife and daughter. Ms. Doucette tried to set up a hotel stay, an appointment for Mr. Desmond with Dr. Murgatroyd before he left New Brunswick, and she tried to set up contact with the Operational Stress Injury Social Support Network Peer Support Coordinator. Mr. Desmond declined all of them.

At this point, Mr. Desmond was not sure where he would be living in Nova Scotia. The Ste. Anne team and Ms. Doucette had recommended he find an apartment, but he said he would most likely reside with Shanna and Aaliyah at the Bordens' house. This is when Ms. Doucette asked to keep Mr. Desmond on as a client, despite the fact that he would normally be transferred

to a case manager in Nova Scotia. She thought that his continuity of care would be difficult enough based on his move.

At this point, it appears to have been a universally-held belief that Lionel Desmond's best option was to transfer his care to the OSI Clinic in Nova Scotia. In fact, this seems self-evident. Although it is obvious that moving between provinces and switching healthcare providers would always be disruptive and probably deleterious to treatment progression, the OSI Clinic was clearly his best option. It is true that the OSI Clinic in Dartmouth was in its infancy at the time and it was unclear whether there was a policy requiring a family doctor to be in place. Nonetheless, there's no indication that this was a reason Mr. Desmond declined to seek access to the clinic and there's no indication he even knew about the policy, if it existed, and there's no indication he would've been turned away. In fact, the referral was made and Ms. Doucette was in contact with the clinic, but it was in Dartmouth, a few hours away from Guysborough County, and that was Mr. Desmond's stated reason for not wanting to go there. VAC would've paid for mileage, meals, a companion, and an overnight stay, if necessary, for Mr. Desmond to obtain treatment there. Mr. Desmond declined. Ms. Doucette tried to get him to access telehealth as Plan B, but he

declined.

(11:10)

At this point in the narrative of this Inquiry, the recommendation for a neuropsychological assessment made by the treating team at Ste. Anne took on a life of its own. The recommendation was based on observations of mild cognitive impairment. Most, if not all, of the psychologists who saw Lionel Desmond talked about mild cognitive impairment being a common symptom of depression and/or PTSD from which he suffered. The idea of the assessment was to determine the cause of the cognitive impairment in order to inform treatment. What the recommendation did not name was that Lionel Desmond was not able to function. Dr. Rogers observed mild cognitive dysfunction in Lionel Desmond. Dr. Gagnon observed mild cognitive dysfunction in Lionel Desmond. Dr. Murgatroyd observed mild cognitive dysfunction in Lionel Desmond. None of them assessed him as unable to function in daily life.

What we also know is that neuropsychological assessments, and those qualified to do them, do not grow on trees. Dr. Gagnon, who was one of the people who recommended the assessment in the first place, also said that she would not be surprised if it took several months to get one. If there was an optimal

place to get one in this case, it would've been Montreal, not Guysborough County.

Ms. Doucette was aware of the recommendation for a neuropsychological assessment. She had made inquiries with respect to a service provider, to no avail. Meanwhile, she understandably prioritized treatment at this time. While the assessment could inform treatment, it would be of no assistance if there were no treatment to inform. Ms. Doucette provided Mr. Desmond with names of therapists, including Cathrine Chambers. He did not follow up as he had promised Ms. Doucette he would. She then facilitated his intake with Cathrine Chambers who had advised her that Ms. Chambers had never heard from Mr. Desmond as planned.

When Ms. Doucette was in Nova Scotia in November 2016 during a personal vacation, she even offered to meet with Mr. Desmond in person but he did not take her up on it. While he attended his first and third scheduled appointments with Ms. Chambers on December 2nd and 15th, 2016, he missed his second and fourth scheduled appointments on December 9th and 19th. His fifth and last appointment occurred over the telephone on the day of the tragedy when he entered into a safety plan with Ms. Chambers and promised he would go to the hospital if he felt

overwhelmed and unable to cope. He scheduled a further appointment for January 5th to discuss resources to support him during his transition, having advised Ms. Chambers that Shanna Desmond had asked for a divorce. Sadly, he did not keep that promise.

We have to keep in mind that Lionel Desmond was a human being with agency. Ms. Doucette endured some aggressive questioning when she suggested that it would be beneficial for him to do some things for himself, but we heard repeatedly from the professionals that too much assistance can be a bad thing. Ms. Doucette was aware that Mr. Desmond had limitations, but she also said that sometimes he surprised her by what he was able to do for himself. Again, mild cognitive dysfunction does not mean a person cannot function in daily living. Lionel Desmond complained of difficulty with concentration and focus which we heard is common with both depression and PTSD. However, even Dr. Theriault observed that Mr. Desmond was "quite capable of independent living". Here's what Dr. Theriault had to say about the neuropsychological assessment:

> I don't think that when he came out of Ste. Anne's, although he hadn't had the neuropsychological assessment done, that

that was sort of the driving clinical need that he had. I think it would be more sort of just trying to get him broadly connected with services so that as he settled into his new environment, somebody could take a look at it and say, Well, these are the areas I should focus on first, whether that would be sort of his depression or his PTSD symptoms or some of the social variables that were at play, but inasmuch as we know that he was able to sort of cognitively manage on a day-to-day basis in the sense of being able to complete all the independent activities of daily living, although that might be useful for treatment planning at some point, it probably wouldn't have been my immediate concern for him.

Meanwhile, Ms. Doucette had gotten Mr. Desmond approved for a clinical care manager to give him a more intensive level of assistance in managing his care in reintegration. She had located Ms. Luedee before the end of August. Yes, there were administrative glitches in getting Ms. Luedee set up in the

system, no doubt about it; however, Mr. Desmond was approved for 100 sessions and he met with Ms. Luedee for the first time at the end of November 2016. By the time they met at length on December 9th, she described him as comfortable, at ease, and positive.

We know that the holidays that year were a difficult time for Lionel Desmond. The truck went in the ditch, there was an argument, and he checked himself into St. Martha's and by January 3rd, it appears that Shanna had asked for a divorce. He spoke to Ms. Luedee on January 2nd and she gave him information on housing support. He spoke to Ms. Chambers on January 3rd and discussed a safety plan. Earlier, on December 9th, he had made an appointment for couple's counselling. He called January 3rd to tell them he would come alone, but that he hoped his wife would later join him. Not only did he display forward-looking behaviour, but he also demonstrated the ability to make arrangements for himself. Nonetheless, catastrophe ensued.

It would be so easy to lay everything at the feet of Veterans Affairs. There is a narrative that's perpetuated of an uncaring bureaucracy, as evidenced by Dr. Smith's comment with respect to a "lack of warmth" there. In reality, Ms. Doucette was the person who drove Mr. Desmond to the airport, put through

extraordinary requests for travel funding, offered to meet with him on her vacation, offered assistance with appointments, and tried to help him solve daily stressors, all with compassion and empathy.

It's so much more difficult to dismiss people as uncaring when they actually have a face and a name and they're sitting in front of you telling you how they wept like a child when they heard the news. Ms. Doucette is one example of the caring team of VAC case managers and service team members who work hard for their clients every day in challenging circumstances.

Dr. Slayter made a comment about Lionel Desmond falling through the cracks. In fact, far from falling through the cracks at Veterans Affairs, Mr. Desmond's choice to decline treatment at the OSI Clinic and to try to find community supports in rural Nova Scotia amounted to a huge crack that Ms. Doucette and others were doing their best to help them navigate clear of. Ms. Doucette was a person that went out of her way for Mr. Desmond, and, yet, she was asked if she felt contrition after he killed his family. Like, are you kidding me?

Every healthcare professional who testified at this Inquiry agreed that such an event is exceedingly difficult, if not impossible, to predict. With the benefit of hindsight, there

are a lot of pieces to this puzzle that seem to fit. Nonetheless, it would be virtually impossible for any one person to be able to piece them all together. It's true; medical records reside with practitioners, police reports are in police possession, ominous text messages went to family members. If only one person or entity were able to see this whole picture clearly and contemporaneously.

(11:20)

That brings me to information sharing. It strikes me as odd that throughout this Inquiry, so many lawyers, of all people, seem to suggest that when it suits us, we should throw privacy to the wind. There was talk of involving Mr. Desmond's spouse in his care, sharing information with his family members or collecting collateral information from them, and it seemed to be postulated that it should be much easier to pass his personal medical information around. In fact, Lionel Desmond did consent at one point to share information with his wife, and then he revoked his consent. He could've involved other family members in his treatment at any time but he chose not to. But healthcare providers have duties of confidentiality. They cannot be reaching out to family members arbitrarily to obtain or disclose personal information without the consent of the

patient. The evidence showed that when Mr. Desmond was asked about his extended family, he did not express an interest in involving them in his treatment.

In Nova Scotia, we have the **Personal Health Information Act**, which, not surprisingly, prohibits the disclosure of health information except in certain specified circumstances or with the express written consent of the patient. This is an important safeguard and mirrors other legislation governing personal information. For instance, you can't have freedom of information without protection of privacy. That's the "POP" in **FOIPOP**. And, in the federal realm, you can't have the **Access to Information Act** without the **Privacy Act**. They are two sides of a coin. That seems to be something that was forgotten, or largely ignored, in the course of this Inquiry when witnesses seemed to be proposing that the sharing of Lionel Desmond's personal health information ought to be much easier. The fact is, obtaining medical records was never shown to be as difficult as some parties assumed it was.

You are going to hear about how it was a failure on the part of the federal administration that Mr. Desmond's caregivers could not access his CAF medical records. This is a myth because the fact is, no Nova Scotian medical professional ever

asked CAF for them, nor did Mr. Desmond submit any information request to CAF. The simple one-page form was actually emailed to Mr. Desmond. It is little more than name, rank, and serial number. He never filled it out to allow CAF to release his records to treating professionals in Nova Scotia. The process is not much different than if a civilian wishes to have their records sent to a new healthcare provider. This has repeatedly been termed a failure to share information. There can be no failure to share medical records when the records are never requested, and the proposition that it would be impossible for Lionel Desmond, with mild cognitive impairment, to fill out and mail a one-page form is baseless, particularly when the record shows he was able to make and break appointments, carry on the functions of daily living, sell his home, et cetera.

In any event, we understand that CAF medical records are now provided to releasing members, and CAF and VAC are always striving to do better. That's why they have ombudsmen and standing committees. That's why VAC did an internal review identifying opportunities for improvement.

As for the Ste. Anne records, we heard that Mr. Desmond should have received a copy of the discharge summary, but he did not. While a copy was eventually provided to VAC, the discharge

summary could've been requested by a Nova Scotian healthcare provider directly from Ste. Anne.

In any event, what everyone knew at this time was that Lionel Desmond needed psychotherapy, a psychiatrist to follow up with medications, and his treatment plan was discussed on the phone with Ms. Doucette and Ms. Luedee and Mr. Desmond. Ms. Luedee was going to help with housing and gym membership and Ms. Doucette was going to work on getting care providers and a neuropsychological assessment.

I want to turn to the intimate partner violence aspect of this narrative because this is perhaps the most difficult and intractable piece of this entire puzzle. Intimate partner violence is a scourge on our society and it thrives in an environment of secrecy. Once again, it raises the conundrum and the tension among autonomy and agency of the person, consent and information sharing.

Although it doesn't seem that Lionel Desmond had a history of physical abuse toward his wife, he certainly displayed some behaviours we might now recognize in hindsight as coercive control which is often a hallmark of intimate partner violence. He hid Shanna's keys so she couldn't get to work. He called police to track her down when she had left the house. While

living apart, he sent cryptic text messages indicating suicidal intent, possibly to see how she would react. During one occurrence when RCMP attended Mrs. Desmond's residence, the constable provided her with contact information for the Naomi Society. She indicated she did not feel in danger and that she did not wish to contact the Naomi Society at that time. However, in circumstances where there was clearly no chargeable offence at play, the RCMP still ensured Shanna Desmond had the name of a local resource in hand should she wish to contact it in future.

Later on, Lionel Desmond sent some very disturbing text messages to Mrs. Desmond and her sister. He told other family members he was worried he would snap. Dr. Gagnon, who treated Mr. Desmond in Montreal from June to August 2016, said that he described yelling and shouting in the context of family arguments, but that without more, she would not have identified domestic abuse.

The trouble is, some of the most telling information was in the possession of people who did not share it. Perhaps they didn't know with whom to share it or how. Perhaps the tidbits of information in their possession, without more, did not seem that bad. Other information was in the possession of those who

could not share it, like the police.

This brings us back to personal information and the limits on disclosure. Dr. Jaffe and others seem to think that police should do more. The reality is that police in Nova Scotia do have significant training to respond to intimate partner violence. They are trained to apply the Ontario Domestic Assault Risk Assessment, or ODARA tool, and to refer high-risk victims. They are aware of resources and organizations to which they can refer victims; but, the fact is, the primary duty of the police is to enforce the law, and there are limits to what they can do when no chargeable offence is committed. Perhaps more germane, there are limits to what police can do when victims are sometimes, for various reasons, not willing to cooperate with police or do not see themselves as actually experiencing intimate partner violence.

Professionals who treated Lionel Desmond did so largely during periods when he and his wife were living in two different provinces. When they did have the opportunity to observe the couple together, such as Dr. Njoku, they observed what appeared to be a couple committed to a future together. Any of the healthcare professionals who interacted with Lionel Desmond would've been legally bound to breach confidentiality and take

action if they had assessed him as an imminent risk to himself or others. Every one of them who testified said they were shocked when they heard the news. Shanna Desmond called the Naomi Society on the day she was killed. Apparently, she did not feel in imminent danger despite the fact that she clearly was.

Some of the same information-sharing considerations play into the question of firearms possession. Officials in the Chief Firearms Officer's office for the Province make the ultimate determination with respect to eligibility to possess firearms. There are robust application and assessment schemes in place to determine continuous eligibility. Background checks are done with police and courts, inquiries are made with respect to criminal history, mental health, and marital history. A reference is required who cannot be a spouse. CFO officials may request more information, such as from treating physicians in a case of mental health disclosure, and certain interactions with law enforcement will generate a FIP - firearms interest police. There are more offences on the books now that generate FIPs than there were before. Mr. Murray correctly pointed out one of the conundrums with firearms license assessment in that mental health aspects are changeable. Any assessment is a snapshot in

time.

(11:30)

The repeated assertion throughout this Inquiry that no one with a mental health condition should be allowed to possess a firearm was damaging and discriminatory. On the contrary, several healthcare professionals commented on the therapeutic value to their patients of participating in longstanding hobbies like hunting and sport shooting. The key is identifying a link between the mental illness and potential for violence. The **Firearms Act** contains mandatory considerations for CFOs and was enhanced last year to include more considerations relating to both risk of harm generally and risk of harm in the intimate partner context where violence was used, threatened, or attempted. Officials in the CFO's office are not mental health experts and must, of necessity, rely to some degree on the opinions of physicians. Their task is not an easy one. Nor should the burden rest solely on their shoulders when others - be they family members, friends, caregivers, neighbours, or employers, for example, are in possession of information that might impact eligibility to possess a firearm.

To conclude, Your Honour, the Desmonds and Bordens and all Nova Scotians wanted answers to try to make sense of the

senseless. The answers that emerge from this process are extremely complex, and, to a great degree, they only come into focus with the benefit of hindsight. Meaningful and workable recommendations are a tall order.

The Attorney General of Canada will not weigh in with respect to recommendations that are not within the legislative competence of Parliament. However, with respect to federal matters outside the scope of this provincial fatality investigation, federal entities are always striving to learn and do better. I sincerely hope that meaningful change can prevent another such tragedy from destroying even one more life.

Thank you, Your Honour.

THE COURT: Thank you, Ms. Ward. All right. Thank you, Counsel. We'll break for this morning. Do you want to come back at 1:00? Come back a little earlier than usual? Unless Counsel have matters that are scheduled over the lunch hour that would interrupt it. We'll just finish a little earlier this afternoon, that's all. All right? We'll come back at 1:00 then. Thank you.

COURT RECESSED (11:33 HRS)

COURT RESUMED (13:03 HRS)

THE COURT: Thank you. Mr. Anderson?

SUBMISSIONS BY MR. ANDERSON

MR. ANDERSON: Thank you, Your Honour. The following submissions are made on behalf of the Attorney General of Nova Scotia. As noted in the brief on behalf of the Attorney General, family, friends and colleagues testified about who Shanna, Aaliyah, Brenda and Lionel Desmond were and what they meant to them. This was a tragedy. Minister Johns extends his condolences to the Desmond and Borden families and condolences are extended to friends and the community.

Dr. Matthew Bowes, the Chief Medical Examiner, recommended a fatality inquiry be held. He explained there were several provincial issues that could only be thoroughly canvassed through the mechanism of an inquiry, that is what we have had here at this Inquiry.

Your Honour has previously noted that this Inquiry has limited authority to inquire into areas of federal jurisdiction, and you've also cited a **Keable** case in your opening remarks which noted: "When an inquiry into a matter that is within provincial competence reveals the desirability of changes in federal law, that the inquiry could submit a report in which it appeared the changes in federal laws would be desirable."

I note that Commissioner Nunn discussed the question of a federal and provincial jurisdiction issue in his report at pages 24 to 27. What Commissioner Nunn did in that inquiry, he commented on areas of potential change to federal legislation and approached his recommendations by addressing them to provincial officials in their continuing advocacy.

Our brief discusses several topics raised over the course of the hearings. They organize into three categories, similar to Mr. Murray: mental health; public safety, which we've identified as firearms; and domestic violence.

We have heard from many highly qualified professionals and friends and family. We've heard about many initiatives, services, programs and plans. We've also heard about new initiatives, services, programs and plans.

The evidence of enhancements regarding mental health already made or in progress included the exchange and transfer of health information. Alyson Lamb testified about the One Person-One Record being in the pre-implementation phase. She also explained that it is a thoughtful implementation over a couple of years.

With respect to the continuity of care from military to provincial healthcare, the Attorney General of Canada notes that

veterans releasing from CAF are now provided with a copy of their medical records. I also note in Sgt. MacLeod's brief that he notes that is the case; that released CAF members receive their Service healthcare records. He also noted and made additional comments regarding older veterans and getting their records.

With respect to assessing suicide and homicide risk, Dr. Rahman testified about a new Nova Scotia Health Authority suicide risk assessment and intervention tool that they have used since 2017.

With respect to culturally-appropriate mental health services, I note from our brief at pages 34 to 37 there's a description of several initiatives. I think most of them are summarized in Exhibit 377. They include the EMHA Governance Group under of the Office of Addictions and Mental Health delivers virtual care across the province. In partnership with the Department of Advanced Labour and Nova Scotia Health Authority increased funding for designated seats for equity-seeking groups and more diverse representation in the health professions. It also includes support for network of black mental health providers is identified as a priority in the mandate of the Office of Addictions and Mental Health.

The **Speak Up for Healthcare** Report was released in February and is being used to develop a multi-year healthcare strategy plan. The Department of Health and Wellness Equity Engagement Division was established in 2021. Its mandate includes internally to identify and remove systemic barriers; externally to ensure community voices, strategic partnerships and lived experiences continue to inform and shape the government's vision for more equitable health system.

I also note new legislation the **Dismantling Racism and Hate Act**. It's had its third reading on the 1st of this month.

With respect to mental health services in rural communities, Develop Nova Scotia is leading an initiative to provide high-speed internet access throughout the province. I'll also note that the announcement this January of new regional African-Nova Scotia Affairs offices in Digby, New Glasgow and the Preston area.

The evidence of enhancements regarding public safety - firearms already made or in progress include with respect to obtaining medical information. Mr. John Parkin, the Chief Firearms Officer, talked about guides and materials regarding mental health used in training that have been incorporated into a new draft standard operating policy.

With respect to access to police databases, Mr. Parkin said that the Nova Scotia Firearms officers are trained to use the RCMP database and that the access is currently a matter of technology.

With respect to preventing the use of licences under review or revoked, there was federal legislation or at least in **Bill C-71**, legislation requiring a transfer to verify the transferee's licence is valid, that was a portion of the **Bill C-71** that has not been enacted. At least yet it hasn't been enacted.

(13:10)

With respect to legislation requiring a licence holder whose licence is revoked to deliver their firearms or otherwise dispose of firearms they possess. That was a portion of **Bill C-21** and that has not been re-tabled, but that's the issue that Mr. Parkin testified about, that when persons whose licences are revoked, if they file a judicial review that they keep their licence.

The evidence of enhancements regarding domestic violence intervention already made or in progress have included with respect to awareness of domestic violence and intervention services, Stephanie MacInnis-Langley and Nancy MacDonald talked about domestic violence and intervention services in Nova

Scotia.

Ms. MacInnis-Langley also testified about neighbours, friends and families, and she also talked about a poll that 73 percent of respondents knew where to get outside help. She added that still leaves us with a gap of people. We need more information to provide to them.

With respect to assessing domestic violence risk, Ms. MacInnis-Langley talked about the use of the Jacquelyn Campbell Danger Assessment, and Sharon Flanagan talked about the use of the ODARA. Drs. Theriault and Jaffe also talked about risk assessments.

With respect to culturally appropriate domestic violence intervention services, Ms. MacInnis-Langley and Ms. MacDonald talked about the ongoing work to ensure programs and services are culturally sensitive and appropriate. Initiatives discussed in our brief at pages 34 to 37 include inter-partner violence.

With respect to domestic violence intervention services in rural Nova Scotia, again Ms. MacInnis-Langley and Ms. MacDonald testified about the intervention services in rural Nova Scotia and efforts to reach various communities.

Dr. Jaffe commented generally on domestic violence initiatives underway in Nova Scotia. He said, "Clearly there

are things currently underway so my recommendation is really to enhance the work that is being done."

He was asked about the appropriate risk assessment process and knowing where to refer people and he said that: "Nova Scotia has been a leader in terms of creating some protocols and policies in this area. All that being said, there are opportunities to further enhance mental health, public safety and domestic violence."

Our brief notes opportunities for consideration when formualting your recommendations. Many are in progress.

There are several suggestions contained in the various briefs from the various participants; we will not be commenting on them. You need not take that silence as an endorsement or a rejection, I anticipate that all suggestions are welcome for your consideration.

Your Honour, this has been a thorough examination of the circumstances under which the deaths occurred and systemic issues. Thank you.

The contributions of the families is appreciated, as are the contributions of the participants, counsel, witnesses, and Inquiry counsel. To our colleagues, we say thank you. Your Honour, the Minister looks forward to your report and any

recommendations.

THE COURT: Thank you, Mr. Anderson.

MR. ANDERSON: Thank you.

THE COURT: Mr. Rogers?

MR. ROGERS: Thank you.

SUBMISSIONS BY MR. ROGERS

(13:14)

MR. ROGERS: Your Honour, on behalf of the Nova Scotia Health Authority together with my colleague, Daniel MacKenzie, we welcome the opportunity to make oral submissions to this Inquiry to supplement the written submissions that have been filed. I intend in my oral comments to break it down into two components.

First, my intention is to cover a brief review of some of the key evidentiary issues and the background that are, in our view, relevant to the terms of reference before this Inquiry and are relevant to those recommendations that touch upon the Nova Scotia Health Authority.

And secondly, more specifically with respect to the recommendations that have been included in the submissions from the various parties, my intention is to go through certain of those recommendations again to the extent that they're touching on aspects that would apply to the Nova Scotia Health Authority and our goal is to offer comment that we will hope will be viewed as constructive comment on those recommendations that are relevant to the Health Authority recognizing that the goal ultimately of this Inquiry, no doubt, is to have recommendations

that are meaningful and impactful and can be implemented.

And so my thought is to cover some of those recommendations where we say yes, that is a laudable goal or others that we say that's valuable but there needs to be some adjustment of that to reflect the realities of how the health care is delivered. So those are the two aspects of the presentation I intend to make and would obviously welcome any comments from Your Honour.

While I'll be covering a number of the recommendations or the possible recommendations that have been suggested or proposed by counsel for the various parties, obviously it's Your Honour's role to be writing the report and the recommendations. So again, we would welcome an opportunity to comment on any potential recommendations or thoughts that Your Honour might be having that would again impact my client, the Health Authority.

The Nova Scotia Health Authority was created in 2015. It arose as an amalgamation and a change from the previous district Health Authorities that operated. So currently, the IWK operates as its own entity; the Nova Scotia Health Authority otherwise operates hospitals and health centres throughout Nova Scotia. Relevant to this Inquiry, those hospitals would include St. Martha's Hospital in Antigonish as well as the Guysborough Memorial Hospital, both of which had been visited from time to

time over his lifetime by Lionel Desmond.

The Nova Scotia Health Authority provides health services to Nova Scotians through hospitals, through health centres, through community-based programs. Much of what this Inquiry has heard in relation to delivery of health care has focussed on the delivery of mental health services through what now are referred to as the Mental Health and Addictions Program.

In terms of mental health and addiction services that are provided to Nova Scotians, it really can be divided into the first component of outpatient and outreach services, which includes emergency departments, such as St. Martha's where Lionel Desmond visited in October of 2016 and again early in January of 2017. Also second, through community mental health supports and third, through inpatient services.

But the Nova Scotia Health Authority is not the exclusive provider of health or mental health services to Nova Scotians. Again, the Inquiry has heard evidence that there are a number of additional sources for provision of those mental health services outside the rubric of the Health Authority, and that includes through family physicians, which are operating separate and outside the Nova Scotia Health Authority system, but also through a number of private providers, including the provision

of private mental health services.

So again, the Inquiry has heard evidence that can come through psychologists, through psychiatrists, through private psychotherapists, through counsellors, through social workers, any number of health fields that touch on and deliver mental health services.

The Inquiry has also heard evidence of another mechanism to provide certain mental health services to a specialized population and that is through the Nova Scotia OSI Clinic, and that's really a hybrid type model because it is an entity that is funded federally, primarily through VAC, and it's available to a limited group of people, those being veterans and RCMP officers, but it is, although funded by VAC, funded federally, is operated in this province through the Nova Scotia Health Authority.

(13:20)

Now VAC acts as a gatekeeper. VAC has to approve or refer a veteran into the OSI Clinic, so there's no means or mechanisms for the OSI Clinic to deliver services unless two things happen. First is there must be a VAC referral, and second is the veteran must agree, must consent to that. Without those two there is no provision of services by any of the individuals who provide

specialized collaborative care at the Nova Scotia OSI Clinic.

We talk in our written submission about distinction between the Nova Scotia Health Authority and physicians, and physicians for the most part act within the Health Authority system as independent contractors; they are not employees. But obviously the physicians and all the other staff members within a hospital act collaboratively and together and those of us who visit an emergency department or a hospital aren't really seeing separate silos of treatment. And the only reason we identified this distinction, which you see by the fact that I'm here representing Nova Scotia Health Authority and a number of the physicians are separately represented.

The only reason I make that point is that if there are recommendations that come, let's say, for example, in the context of education of physicians, that's an area that the Nova Scotia Health Authority has little ability to dictate or control. That ability would exist for the Health Authority with respect to its employees and its staff.

That reality was recognized, I think, in Dr. Jaffe's recommendations because they talked about the need for education in certain areas on domestic violence issues but focussed on the need to look at those regulatory prerogatives for physicians

coming through regulatory bodies. So that's the reason that we just talk in our submission about that distinction between the Health Authority and the physicians.

The next area I'd like to touch on is one that the Inquiry counsel, Mr. Murray, touched on which is the events of January 1 and 2 when Lionel Desmond attended at St. Martha's Hospital in Antigonish. Now there was clearly a misunderstanding, an original mistaken belief by family members that Lionel Desmond was turned away from the St. Martha's Emergency Department. That similar misunderstanding, I believe, was in the mind of Dr. Bowes when this Inquiry was called, but that was not the case.

Inquiry counsel's written submissions and oral submissions acknowledged that that was not the case and the evidence before the Inquiry makes it absolutely clear that Mr. Desmond was not turned away. Rather, when he appeared at St. Martha's Emergency Department on the evening of January 1st at 6:51 and he was seen in triage by Nurse Amy Collins, he very quickly got highly specialized care and assessment. And the evidence, I would submit, is uncontradicted to that effect.

So he was seen by a triage nurse, there was an assessment done, that included a determination or an opinion that there was no suicidal ideation, no homicidal ideation. He was then seen

promptly by Emergency Department physician, Dr. Justin Clark, who made the same determination as part of his assessment that there was no suicidal ideation or no homicidal ideation. Through that assessment I note that counsel for the physicians refers to as "focussed assessment".

Then in what individuals before this Inquiry have referred to as the gold standard treatment, Lionel Desmond was seen very promptly by a specialized psychiatrist, Dr. Faisal Rahman. Dr. Rahman did a 35 to 40-minute assessment, I think that was the focussed assessment that I meant to be referring to, and part of that assessment that Dr. Rahman did is that he did not see that Lionel Desmond met the criteria for involuntary admission under what you've heard referred to as IPTA, the **Involuntary Psychiatric Treatment Act**. And that's the Nova Scotia legislation that puts in place a balancing of societal interests for freedom and autonomy of the patient versus the need for care.

That is ultimately a physician or a psychiatrist's determination that must be made as to whether there's a basis for involuntary admission or involuntary treatment. But what we see is that Dr. Rahman made the determination that there was no basis for involuntary admission.

So while those are decisions that are physician-based, in this case psychiatrist-based, and obviously counsel for the physicians can speak for themselves, on behalf of the Health Authority we see no issue whatsoever with respect to the process followed or the determinations made in relation to the assessment of Lionel Desmond.

Now what then happened after those assessments? Ultimately, it was determined that room would be made available for Lionel Desmond in the observation area of the Emergency Department. And you've heard evidence, Your Honour, that's referred to as a social admission in the hospital vernacular. Cpl. Desmond was actually not admitted, he remained in the Emergency Department so the hospital wouldn't really refer to him as admitted. But the agreement was made in consultation between Dr. Clark and Dr. Rahman that a bed in the back of the Emergency Department in the observation area would be made available for Lionel Desmond to stay that evening.

And even though this Inquiry's role is not to find fault or find any particular challenge to the conduct of the parties, we would suggest that the care that Lionel Desmond received at St. Martha's in Antigonish on January 1st and 2nd was appropriate and that, in fact, is consistent with the submissions made by

Inquiry counsel. The written submission on behalf of Inquiry counsel states that Dr. Rahman's opinion was reasonable.

At paragraph 20 of Inquiry counsel's written submission it's stated that: "Lionel Desmond's interaction with St. Martha's staff was appropriate from a medical treatment point of view." So again I come back to that point that I started with is that the original family misunderstanding that Lionel Desmond was turned away is not, in fact, the case.

The last point I'll make with respect to the events of January 1st and 2nd, it's clear that at that time Lionel Desmond was forward-looking. He agreed as part of his decision to leave the Emergency Department on January 2nd that he would be following up with respect to certain medical appointments and mental health practitioners, that included a return by Lionel Desmond on the morning of January 3rd to St. Martha's Hospital where he went and booked a follow-up appointment with a psychiatrist, Dr. Ian Slayter, an appointment that was scheduled for January the 18th. Very much a forward-looking activity.

And as you recall, the evidence was that that was to meet or to make up for a missed appointment, a no-show, that Lionel Desmond had for an earlier appointment with Dr. Slayter that had been set for December 21.

SUBMISSIONS BY MR. ROGERS

The next area I'd like to cover is going back in time that touches on Lionel Desmond's involvement with the Nova Scotia Health Authority system in the 2016 time period, dating back before the events of January 2017.

Now we've seen in the records that Lionel Desmond is a lifetime resident of Guysborough County, had some historic medical records going back to his birth and his youth. But then obviously through Cpl. Desmond's time in the Canadian Armed Forces and then his time living in Fredericton there is not a substantial body of medical records because he was living out of the province.

Lionel Desmond returns to Nova Scotia in the August to September 2016 time period from New Brunswick. So what then is his first contact with the Nova Scotia health system? Well, again, recognize my comment at the beginning that physicians operate separately and outside the Nova Scotia Health Authority system but we see that there's a visit to a family physician by Lionel Desmond on October 13, 2016 to the Guysborough Medical Clinic where Lionel Desmond is seen by Dr. Harnish. So, again, not a Nova Scotia Health system but, clearly, a visit to a family physician. Then the first touch for Cpl. Desmond into the Nova Scotia Health system in 2016 is his visit to the

Emergency Department at St. Martha's in Antigonish on October 24, 2016.

(13:30)

Now this Inquiry has heard comments of gaps in treatment. So there clearly is a time period where Cpl. Desmond is in Nova Scotia before he comes into St. Martha's in October 24, 2016. But, with respect, it is not the Health Authority's role or hospital's role to go find patients who have moved to the province. The patients come to the Health Authority and the Health Authority doesn't go to the patients.

So until that first visit of Cpl. Desmond to the Nova Scotia Health Authority's hospital in Antigonish in late October, there is no ability or there is no gap in the provision of treatment through any of the entities in the Nova Scotia Health Authority system.

Our written submission then spends some time going through the various touches that Cpl. Desmond had with various physicians and entities through the fall of 2016. It is not my intention to repeat those but what we do see is that on four occasions, Cpl. Desmond makes visits to the Guysborough family physicians where he sees Dr. Harnish initially, then Dr. Ali Khakpour, then Dr. Ranjini Mahendrarajah and then to

psychiatrist, Dr. Ian Slayter. So, again, no involvement by the Health Authority system until October 24 and then we see some access to family physicians and psychiatric services.

The next area I would like to touch on involves the Nova Scotia OSI Clinic that I made reference to earlier. As others have said in their submissions, that clinic in Nova Scotia was in its infancy in that time period. We heard evidence about the growth of the facility over the period of years leading up to today. There is a lack of qualified or there's a dearth of qualified psychiatrists and psychologists and it's difficult to recruit staff but the OSI Clinic has been able to grow and recruit more staff to be able to provide more services through the collaborative model through which it operates. As I said earlier, it's a federally-funded entity, primarily through VAC and Nova Scotia Health Authority operated.

Again, we know that Lionel Desmond had treatment through an OSI facility because there a number that operate throughout the country. He had that treatment through the Fredericton OSI Clinic where he received multi-disciplinary service. The Inquiry has heard evidence that it's a good model for the delivery of service and I think that's quite clear from the evidence before us but it's interesting that Lionel Desmond also

would have known the type of services that were available to him. But what's also absolutely clear in our submission by way of the evidence before the Inquiry is that it was Lionel Desmond who declined to receive treatment at the Nova Scotia OSI Clinic. He not only declined to get treatment at the Nova Scotia OSI Clinic, which is located in Dartmouth, but he also declined the invitation to telehealth services which were then being provided through that entity. Now that's his choice to make but the reason he did not get those services is as a result of his decision to decline to get those services, similar to those which he had available to him in New Brunswick.

Now the Inquiry has also heard evidence about a potential referral into the Nova Scotia OSI Clinic in September and October of 2016 and has heard evidence and some of the submissions before the Inquiry today have made reference to potentially being a policy in place at the Nova Scotia OSI Clinic that a patient would have needed to have had a family physician in order to access psychiatric services at the clinic. And I think it's important to recognize what, in my submission, is the evidence before this Inquiry, is that in the fall of 2016, there was not a policy that a veteran required a family physician in order to access psychiatric services. Rather, that

determination was made on an individual basis. So if a veteran did not have a family physician, then a multi-disciplinary team would meet and determine whether it was possible to provide the services that were necessary without a family physician being in place. So it was an individualized assessment that was made. But it was not the policy in the fall of 2016 that a family physician was required in order to access services at the Nova Scotia OSI clinic.

Now it was a policy for a short period of time early in 2017, approximately from the first week of January until funding was put in place that gave rise to a family physician being brought on staff at the Nova Scotia OSI Clinic. So for a period of several months in early 2017, it was a policy.

Now most of this is irrelevant, we respectfully submit, because whether there was a policy or not, or whether Mr. Desmond had a family physician or not, is not the reason for him failing to go to the OSI Clinic in Dartmouth. That was his determination that I'm not going to elect to receive services there. I prefer to receive services in my home community.

We also, Your Honour, take issue with the suggestion that Lionel Desmond did not have a family physician in the fall of 2016. I have made reference to the three family physicians he

saw in the Guysborough clinic through the fall of 2016 and it's also important to recognize that when Lionel Desmond went to St. Martha's Hospital on October 24 of 2016, he was seen by mental health nurse, Heather Wheaton, who asked him a number of questions and did a detailed assessment. Included in that was the reference that asked who the patient's family physician was and, clearly, what was noted there was Dr. Ranjini. So Lionel Desmond, in his mind, on October 24, 2016, believed he had a family physician.

Now, again, we say this is all irrelevant because the lack of a family physician, which we say is not the case, is not the reason that Lionel Desmond was not seen by the OSI Clinic in Dartmouth.

The next point I would like to cover deals with the interplay between privacy rights, rights of autonomy, and broader societal desire to protect the public or protect patients. The Nova Scotia Health Authority, its staff members, physicians, psychiatrists in this province, operate under particular legislative obligations that deal with the balancing of those interests. So there is the need to balance treatment and care with personal autonomy and privacy rights. And there are two important pieces of legislation that this Inquiry has

heard about that are important to keep in the forefront of any consideration of any recommendations, we respectfully submit, and that's both the IPTA, the **Involuntary Psychiatric Treatment Act**, and PHIA, the **Personal Health Information Act**.

Section 17 of **IPTA** provides the tests that must be met in order to proceed with involuntary admission or involuntary treatment and it is a balancing of those interests.

In the context of **PHIA**, there is again a balancing of interest that's a legislative obligation. **PHIA**, although it doesn't use the words circle of care, talks about that concept where it may be necessary for healthcare providers who are within the circle of care of a patient to be able to access personal health information in order to assist in the treatment and care of a patient.

(13:40)

But it's an important balancing that must reflect the personal autonomy or right of a patient. As an example, I am advised that there are Nova Scotians who exercise their right to tell the Nova Scotia Health Authority to seal their medical record, to make it not available to anyone else who is ever looking to provide care. So the persons who would normally be within the circle of care who would access health records to

assist in the delivery of their care will have no access to that if a patient opts, because they've got the personal autonomy right to do, to have all those records sealed. And while that's not a decision I would make, it is a decision that some people make and it's part of their personal autonomy and right to make those decisions.

PHIA, through section 33, talks about the limits of use of personal health information and also describes roles of healthcare record holders that are defined as custodians. **PHIA** defines personal health information and establishes limits on custodians' rights to collect personal health information.

So even though in a particular context we may say, yes, it would be helpful to get more information from other sources, that can be done only if it's done in a manner consistent with the dictates of **PHIA**.

The last point I want to cover before turning to certain of the recommendations deals with some of the evidence this Inquiry heard from Dr. Scott Theriault and Professor Peter Jaffe. Dr. Theriault, a highly qualified psychiatrist, testified as an expert. Dr. Theriault stated that "reliably predicting suicide is difficult, even moreso homicide suicide". Dr. Theriault stated that he's not aware of any tools that could have been

used to predict Cpl. Desmond's risk of violence.

Dr. Jaffe, by contrast, and this was referred to in Inquiry Counsel's submissions, referenced the provision of his report that stated that "homicide and suicide was predictable and preventable with hindsight". And that was in light of all the available information to the Inquiry.

Now Dr. Theriault did not agree that these tragic events that bring us here were predictable. But even if we look at Dr. Jaffe's comments, he's saying predictable and preventable with hindsight. And that's with hindsight of all the information, the reams of information available to this Inquiry.

Now I know we're not governed by press reports here, Your Honour, but those words that these homicides and suicide were predictable and preventable in a number of press reports, don't include the caveats with hindsight. And I would suggest it's somewhat unfair and would be a mischaracterization of the evidence before this Inquiry to suggest that the family members should have been able to predict the horrible events that occurred here. Or, similarly, any of the health professionals that dealt with Lionel Desmond in the weeks and days and months leading up to this could have predicted this would have occurred.

We absolutely agree with Professor Jaffe's comments with respect to the need and importance to deal with the scourge of domestic violence. Domestic violence extracts a terrible toll in this country. The Health Authority absolutely agrees that increased public and professional education of domestic violence issues and a greater awareness of the risk factors of domestic violence is important and is laudable and probably should be a recommendation coming out of this Inquiry. But we do not agree that these homicides and suicide were predictable and preventable. It is not an exact science to predict future behaviour. The best we, as family members, anyone who is contemplating suicide or experiencing any mental health issues, or any health professional can do, the best we all can do is exercise our personal and professional judgement, our clinical judgement, to assess what we're seeing at a point in time.

So that's the exercise of professional clinical judgement attempting to predict future behaviour, as I say, is not an exact science. It's a difficult task for psychiatrists to predict or say that their conduct could have prevented such a tragic event because it's not just psychiatrists or physicians, that same thought process, the same attempt at exercising professional clinical judgement would apply in a number of

contexts when predicting future behaviour. It must be the same assessment that would be made by parole boards. And while the goal is clearly to identify risks and make decisions that reflect those, it is not an exact science. Because human behaviour doesn't allow for that level of assurance about what's going to happen in the future.

Similarly, Your Honour, the decision that you and your colleagues on the Provincial Court would see in any bail hearing. All the court can be asked to do is exercise professional judgement based on information before you.

So we would ask this Inquiry to accept the opinion of Dr. Theriault over that of Professor Jaffe with respect to this predictable and preventable comment.

THE COURT: But isn't part of that predictable opinion based on, for instance, if I had given all the circumstances and made all the circumstances available to Dr. Theriault, if he had the same background, knowledge, and training in domestic violence that Dr. Jaffe had, if he had been involved in a domestic violence death review committees in Ontario for as many years as Dr. Jaffe had, if he had sat and looked at and had teased out the 40-odd factors that had been identified, and had in front of him all of the background information with regard to

Lionel Desmond, or Cpl. Desmond, and saw that there were 21 of these, and he was then given as an exam question, What do you think is going to happen here, Dr. Theriault? I would put money on the table that he would say domestic violence is looming very, very large here. It may not happen on day one or day 100, it may not result in death but domestic violence is going to happen in this scenario. Do you think Dr. Theriault would agree with that?

MR. ROGERS: I think he likely would but I appreciate that the caveats you are saying on domestic violence because that next step from that, which is far too rampant in our society, to the incredibly rare event of homicide/suicide, I think is a leap and that's where I'm having difficulty accepting Professor Jaffe's comments in that regard.

THE COURT: I am going to suggest to you that if you simply look at the rare event of triple homicide of a family and then a suicide, that in fact might be a very rare event. But given Cpl. Desmond's circumstances at that point in time, suicide was not an unpredictable event in his life nor was domestic violence an unpredictable event in his life. The fact that the two of them would come together and would come under that label of homicide/familicide, which is a rare event, yeah,

if you break it that day. But if you look at it in the two component parts, neither of those two component parts are that rare or unpredictable. Would you agree? Domestic violence and suicide? They were looming large in that man's life? How they were going to come together or if they ever came together in that predictable ... in that way, I will agree with you. That part of it is unpredictable. But the fact that there was a suicide, I don't think was unpredictable. And the fact that there was domestic violence, I don't think was unpredictable either. But together in that moment, in that time, I would agree with you.

MR. ROGERS: And I accept what you're saying, Your Honour. The only caveat I would say is that my recollection is that Dr. Theriault, when he testified, did talk about suicide itself being a very rare event which made it difficult to make the leap from some risk factors to that will occur. So that's the only caveat that I apply.

(13:50)

THE COURT: Well, if we look at the statistics for suicide in individuals that were similarly placed to Lionel Desmond, given his age, given his background, given where he grew up, given his time in the military, his PTSD diagnosis and

what he endured there, you know, in that context, it may not be as rare and unpredictable as you might find in a lot of other nonprofessional or other professional settings. But, at any rate ...

MR. ROGERS: And look, I do recognize that Professor Jaffe's comments did include the caveat with hindsight and with all the information before us. So we now have text information, including disturbing texts with the family members that healthcare professionals wouldn't have had, a whole panoply of information we now have that individual caregivers would not have had.

THE COURT: I agree. I think that's part of Dr. Jaffe's point is that there's a real educational process should be here so that an event that occurs and a comment that's made, there is a way to share that information so that there is a way for it to become more centralized so that Dr. Slayter, for instance, if he had had more information available to him, he may have taken a different position or he may have taken a different course. I appreciate that's Dr. Slayter, right. But, you know, I think the point that Dr. Jaffe was making was the point that the more people are informed, the more people that have healthcare providers, for instance, I'll use that as an umbrella label,

that would come into contact with individuals like Cpl. Desmond who are aware of what they should be looking for and the importance of some of the information that they can collect instead of being, you know, I appreciate that if you're focussed on mental health that you cannot be so focussed on that to the exclusion of what would be an indicator of potential domestic violence or intimate partner violence. And it's being able to recognize that and then do something with it. What you do with it becomes maybe as part of the challenge. But to be aware of it.

MR. ROGERS: And you'll hear me say in a few moments, Your Honour, that the Health Authority is in agreement with virtually all the recommendations of Professor Jaffe in terms of increasing that level of education so that individuals are better informed, know where to refer people to, whether it's a perpetrator or a victim of domestic violence, to get those kind of services that we've heard, the Province describe as being available and increasingly available so that information piece is important. We recognize that.

THE COURT: Thank you.

MR. ROGERS: So my intent next, Your Honour, is to go through some of the recommendations and, as I say, I recognize

that it's ultimately for Your Honour and the court to be making those recommendations but we thought it potentially helpful to offer some comment and insight with respect to certain of those.

I'm starting with a number of the recommendations, largely the ones that touch on the Health Authority in the submissions of Inquiry counsel and I probably won't read them in their entirety but I'll reference the paragraph number, just in case you wanted to go back to those.

So the first I want to touch on is the recommendation at paragraph 51 that suggests the NSHA and the Nova Scotia Department of Health and Wellness assess the availability of neuropsychological assessments in the province and, if needed, take steps to ensure they're more readily available.

So these assessments already exist as a service provided by private providers in Nova Scotia who are capable of performing those specialized assessments where necessary. Typically, I see those neuropsychological assessments often in litigation contexts, that lawyers are often commissioning those, employers often ask for those. And neuropsychological assessments are a point in time assessment that, and there are limits to their clinical value. So, obviously, have some purpose but we just suggest is not a panacea. But, for the most part, those are not

provided through the Nova Scotia Health system, through the public system. And if Your Honour were to be of the view that such a recommendation should be implemented, then in order for those to be provided through the Nova Scotia Health system, there would need to be funding. So recognize that if Your Honour is suggesting a recommendation for the delivery of services through the Nova Scotia Health Authority system, we respectfully suggest that any such recommendation come with a recommendation for funding.

THE COURT: Of course.

MR. ROGERS: The next recommendation from Inquiry counsel, at paragraph 56 of their written submission, is that the Health Authority continue to update its suicide risk assessment policy and tool based on the most up-to-date information on suicide risk assessment and continue to train staff engaged in mental health on the SRAI policy and tool.

And a very similar recommendation came from Ms. Miller's submission, though that one added the caveat that that reassessment be done on an annual basis. And the Health Authority is in agreement with recommendations to continuously review and consider those policies for suicide risk assessment. So is in agreement with the wording of the proposal from Inquiry

counsel. We do have a concern or issue if the word "annual" be added in as was suggested. These policies need to have an opportunity to actually be implemented and observed and action, determine if there's room for improvement and an annual is too vast. My recollection is that the evidence, Your Honour, is that that policy is considered every four years already as part of an ongoing process that the Health Authority has in place.

So if the policy is reviewed annually, then the review team would simply be operating in a continuous cycle of review without any opportunity to learn and digest and make suggestions for any potential future change.

The next set of recommendations are at paragraphs 64 through 67 of Inquiry counsel's written submission and are the recommendations that came out of the Health Association of African Canadians Report. And they are also recommended in other submissions from the Inquiry.

Now it was only late in the day of this Inquiry that we heard the evidence, the powerful evidence from the panel who presented on behalf of the Health Association of African Canadians. And so if Your Honour determines that those diversity and inclusion issues or the delivery of culturally competent care fall within the jurisdiction of the Inquiry, it's

important to keep in mind that we really, despite the number of days of hearing and the number of exhibits, we really don't have evidence as to whether those folks, who were involved with Lionel Desmond in delivering health care or mental health services, were trained in delivering culturally competent care or did so because we really didn't touch on those issues until we heard from the panel.

So we've submitted to the Inquiry Exhibit 375 which touched on steps that the Health Authority is taking to deal with those important issues of equity, diversion, and inclusion. And, in that submission, the Health Authority has indicated it has room to improve. Better steps need to be taken to deliver culturally competent care but it would be totally inaccurate to make a determination or assume that no steps have been taken and there isn't a recognition of the need to be doing that. And so our submission at Exhibit 375 set out some of those steps, though as a further example since that time, I am advised that Mental Health and Addictions is hiring an advanced practice lead in cultural competence and equity diversion and inclusion, will focus on training clinicians and others within the mental health and addictions program to provide culturally responsive assessment and psychotherapy to folks from racialized and

marginalized communities. So steps have been taken, are being taken, but there is room to do that better.

(14:00)

THE COURT: There was a publication that came out of Nova Scotia Health. It was entitled **Addressing Racial Injustice Within the Nova Scotia Health System** and it was subtitled **Summary of Conversations and Discussions of Next Steps May 2021.** And that summarizes, I guess, the view of the CEO at the time, Dr. Carr, with regard to recognition of certain situations and the need for new and better directions. And I take it that's what Exhibit 375 was really kind of focussed on. So those two things could kind of be - would be looked at together. Am I correct?

MR. ROGERS: Absolutely correct.

THE COURT: Thank you. That's the clarification I needed, so thank you.

MR. ROGERS: And then just to touch on the specific recommendations from that committee that have been repeated by Inquiry counsel. So the first is talking about implementation of comprehensive virtual care for rural African Nova Scotians. And so the Health Authority agrees that that makes sense, but we would suggest that if Your Honour is looking to do that, it is

not just a Nova Scotia Health Authority issue, but is broader than that.

Then if we look at the second recommendation, it refers to the need and benefit to recruit black and diverse mental health providers. And the Health Authority again suggests that's absolutely a laudable goal, though we wouldn't limit it to mental health providers. The Health Authority believes that's important in terms of additional recruitment from diverse communities but it's not limited just to the mental health field.

The third suggests that there should be educational scholarship, and I think the recommendation talked about the Nova Scotia Health Authority educational scholarship for African Nova Scotian registered nurses. And we would just comment that the Health Authority doesn't provide scholarships. That's not part of its role; that's not part of its funding. There are some scholarships that are provided, and I believe some to marginalized communities, through various hospital foundations, but those are really separate entities outside the Health Authority. So we just offer the view that if Your Honour was looking at some kind of recommendation on educational scholarships or funding need to be recognition that that's not

the role of the Health Authority and it has no such funding for that.

The last recommendation that came out of the HAAC Report and panel presentation was in relation to a network of black mental health providers, and I think that's really more a provincial role and for them to be commenting on.

The next recommendation that I want to touch on is found at paragraph 77, of the written submission of Inquiry counsel, and it was to ensure that frontline professionals in multiple systems such as health, mental health, education, social services, and the justice system are up to date with current information about domestic violence and then it talked about a number of components of that. And that really is part of what came out of the comments from Professor Jaffe and the Health Authority is in full agreement with that enhanced education.

Next is a recommendation from Inquiry counsel, at paragraph 131 of their submission, that the Health Authority designate a person as a navigator to assist veterans who are being released from CAF or who are relocating to the province in obtaining their medical records and having those ingested into their electronic medical record for easier access to Nova Scotian clinicians. And a similar recommendation, though with some

different components, was included in Ms. Miller's submission that talked about potentially establishing a new office. So there are a few things I want to cover in relation to that recommendation. And just to go to Ms. Miller's recommendation, it was to establish what was referred to as a "record access solution office" with staff designated to assist Nova Scotians with respect to accessing their records, and also included the contemplated role for that new office to gather records. And the view of the Health Authority is that there may be an important role to ensure that individual Nova Scotians or healthcare providers know the right process to secure health records, but we respectfully submit it would be counterproductive to establish a new office that would be the gatherer or the collector or the disseminator or the custodian of those records, as I'll comment on the reason for that in a moment.

So we are of the view that there is merit - potential merit in ensuring that there is a place individuals can go if they're having difficulty understanding how to get records. And that, I think, is what was contemplated in the recommendation from Inquiry counsel because it's saying "designated person to act as a navigator to assist veterans or persons who are relocating in

obtaining their records and having them ingested".

So it has to be recognized where health records exist. There will be a number of cases where health records may be in another provincial system and they're coming into our provincial system. So it's a province-to-province healthcare system. But there will be a whole series of cases where a patient may have medical records in another jurisdiction that are not in a public system, that are with a family physician, that are with a private psychologist, a counsellor, a physiotherapist. And accessing those records from physiotherapist to physiotherapist has nothing to do with the Nova Scotia Health Authority. So it couldn't obtain the records from one person and sit in the middle between those two entities. So there would be a number of circumstances where this function of moving medical records from one source to another would not involve the delivery of any care through the Nova Scotia Health Authority system.

There are a number of cases where physicians make a determination they need a health record that's in another jurisdiction and they know exactly how to get that material; either to get the patient to get it and bring it or to get a consent from the patient so that the result can come. So if somebody shows up in the emergency department at St. Martha's

and realizes a blood test result that was done a week earlier in Charlottetown that's going to be relevant and helpful, they know how to get that information directly to come back into St. Martha's so the treating physician can access that and determine what to do.

We would argue that it would be counterproductive and problematic if you created a new office that had to get that information, because you're asking a physician who knows what they want to go to an office that presumably would have to be staffed 24/7, to then make the request over to the Charlottetown hospital, get it, and then get it back to over to the hospital, which is going to be adding a layer of bureaucracy and time and effort which is not necessary.

THE COURT: So the suggestion that there be an individual who is designated as a navigator, for instance, so you would have the doctor who is informed enough to be able to pick up the phone and make the call and get what he or she or they need, wouldn't need a navigator, but an individual who has a doctor's appointment and the doctor says, Well, bring all your records with you when you come, and that person goes, How do I do that?

MR. ROGERS: And so if ...

THE COURT: That person would benefit from a navigator, would they not?

MR. ROGERS: That's right. So if Your Honour is looking at doing that, there is a potential role for doing that. And we can see that ...

THE COURT: That's why we're just having a discussion.

(14:10)

MR. ROGERS: That's right. And so the Nova Scotia Health Privacy office could do that, and does a bit of that on an *ad hoc* basis in saying, You're having difficulty getting your healthcare records in Nova Scotia? Here's how you do it. You're having difficulty getting records from another source outside the jurisdiction? Here's how you do it. So a little bit of that is done on an *ad hoc* basis. So if Your Honour thought there was merit to that then, again, with funding, that information source could exist within a privacy office of Nova Scotia Health Authority. So that could be done, but what we say is it should not involve that entity acting as a custodian of documents, the entity that gets them as opposed to providing information to either the healthcare provider, the physician at St. Martha's, or the patient - here's how you get these records.

Now, it can also operate to ensure that a patient's records

are put into the Nova Scotia healthcare system.

THE COURT: That's what I was going to ask. It's one thing to get them; it's another thing to put them into the system to make them available so that when the person shows up in the ER, that record that came from a distant spot is now in the Nova Scotia healthcare record system.

MR. ROGERS: That's right.

THE COURT: So the ER doctor or physician, or whoever, would have access to it.

MR. ROGERS: And I'm told that can be done and that doesn't require them to be the intermediary of these materials, receiving the documents because all this has to be done with consent.

THE COURT: Yes.

MR. ROGERS: We cannot underestimate the importance of needing consent from patients to access all these records, but if a veteran comes with that record that CAF has now provided him and says, I want to be putting these into my electronic medical record in Nova Scotia, then that office can do that. And this Inquiry has heard evidence that that exists now. There is functionality to do that under the two systems that operate in the province currently, and the plan is to have that as part

of the new system in the province in developing of OPOR.

THE COURT: You're suggesting that if there was a person that was the equivalent of a navigator, they could help an individual, but the healthcare record wouldn't come back to the navigator, it would come back to the individual who would then have to bring it and ask to have it added to their electronic record.

MR. ROGERS: That's right.

THE COURT: That's the difference.

MR. ROGERS: That's the difference.

THE COURT: So that the navigator is not the recipient of the health record.

MR. ROGERS: That's right.

THE COURT: Unless, of course, the individual signs a consent that the healthcare record come to the navigator and be immediately ingested into their healthcare records.

MR. ROGERS: And that can be done. So if those records come to there and say, Here's my record from British Columbia, that can then be entered in the system.

THE COURT: Yeah. Just a matter of getting the consent in the direction that the navigator's office is set up to deal with. All right, thank you.

MR. ROGERS: That's right. And, so, again, if Your Honour feels that that is an important role, it is something that could be done, again, with the funding. And, presumably, someone would need to make a determination as to whether that facilitation role would also be provided to those circumstances that I described a moment ago where it is a private source looking for information from another private source.

THE COURT: All right. Doctor to doctor or doctor's office to doctor's office is what you mean?

MR. ROGERS: That's right.

THE COURT: Or private clinician to private clinician? Yeah.

MR. ROGERS: And I'm not sure that I've asked my client this question, but I assume that they, in theory, could become knowledgeable about how that's done so that advice could be given to a patient saying, Well, look, when you're looking for records from a family physician or, you know, from a family physician who's retired in Ontario, somebody may have knowledge about how to access records in Ontario from family physicians who have retired, so there might be a source of information that this office would have that they could be passing along to persons who have those questions.

THE COURT: Yeah. But I would think that if you have the capability to locate an office, they're going to become, effectively, the subject matter experts in how to navigate the various routes that you might have to follow to get records, whether it's a private record or an institutional record or a private therapist's record.

MR. ROGERS: That's right. And recognize as well that that request always must meet the requirements of the custodian of the record extra-provincially. So every custodian will have its own system. So we've heard of VAC's form that an individual needs to sign. Every hospital, every physician, would have different requirements of what must be done by way of consent in order to provide those records. So it's not as if any person seeking the records in Nova Scotia, whether you're a physician, a private healthcare provider, or a hospital, has the ability to dictate that the records must be provided. All they can do is request and hope that that meets the requirements of the extra-provincial custodian.

THE COURT: And isn't that where the log jam is? So if you've got one entity that's able to kind of break through that log jam consistently, then I think that would be desirable.

MR. ROGERS: It is. Information flows from different

hospitals and from other jurisdictions all the time, so this is a really common practice.

THE COURT: Right.

MR. ROGERS: So it would be a misnomer to suggest that this doesn't occur. That wouldn't be accurate. That these types of requests are frequently made and those records are provided all the time. And we've heard evidence that the current electronic systems are not perfect because we've only, for seven years, been one Health authority. We used to be different systems. Those different systems selected different electronic systems to maintain electronic records, and they don't entirely speak to each other, though you've heard evidence that, through SHARE, there is an ability for certain information to be accessed. So this is an area that calls out for improvement, and that's what One Patient-One Record is looking to do which is, again, a provincial initiative that the Health Authority fully supports, so that's going to be looking at improving matters; but, again, we've come a long way. I mean if you go back 20 years, every hospital has its own separate silo with a paper record, so you weren't getting a record from the Digby Hospital if you showed up in the Yarmouth Hospital until somebody put it in the mail.

So there have been improvements in all these systems. Is it perfect? No. Is there room for improvement? Absolutely. And One Patient-One Record is going to go a long way to doing that.

THE COURT: Thank you.

MR. ROGERS: So I think I've touched on, in those comments, Your Honour, on the next recommendation at paragraph 132 of Inquiry counsel submission where it was proposed that any electronic recordkeeping system maintained and utilized by the Health Authority should have a specific category for records provided by a veteran relocating to Nova Scotia. And I think I've touched on that and there is the ability for those records to be currently uploaded to the electronic medical record of a patient. And, certainly, it will be contemplated that that similar functionality would be included in One Patient-One Record though, again, that's all up to the Province to determine but we'd be quite surprised if that were not part and parcel of what we put in place.

So, next, I'd like to turn to some of the recommendations that were included in Ms. Miller's submission on behalf of the late Brenda Desmond and the series of recommendations that deal with health information and the OPOE system and include

recommendations that the Health Authority and the Department of Health should ensure the development of OPOR system in a manner that identifies and provides easy access to mental health records generated in the public health system, and then include a portal for private healthcare physicians to access Health Authority records, and should develop a category within the existing electronic intake and discharge forms that identifies and alert treatment providers that a patient is in the military or a veteran. And, as I said earlier, the Health Authority certainly does not dispute the need and benefit to proceed with a better electronic healthcare record system which the Province is in the process of developing through OPOR. We're in agreement with any recommendations that be implemented. The timing and scope of that clearly rests with the provincial government, as with decisions as to how it will operate, but the Health Authority is on board with any recommendation that allows outside medical records to be uploaded. But, again, that can only be done with patient consent.

(14:20)

The next recommendation I want to touch on is found at page 35 of the submission of Ms. Miller, and it proposes the Health Authority create a category within existing electronic and paper

healthcare records to identify if a patient has a firearms license and the date of issue to allow physicians doing risk assessments to determine quickly whether the patient does, indeed, have an access to a gun or license. And, with respect, the position of the Health Authority is that such a recommendation would be problematic and potentially detrimental to the delivery of health care and contrary to statutory obligations.

The question of whether a patient has a firearms license is not personal health information as defined in **PHIA**, and our position is it therefore does not belong in a health record and it would not be information that would be collected for a healthcare purpose as defined in **PHIA**. The purpose of **PHIA** involves a balance between the rights of individuals to protect their personal health information and the need of custodians to collect, use, or disclose personal health information to provide support and to manage health care. So that's distinct - the recommendation here - distinct from patients who are asked by, typically, a mental health professional during an SRAI assessment whether they have access to a firearm, because that is a question that's asked to a number of individuals. But license holding is not synonymous with access. The real key is access. But,

importantly, we need to be recognized, for the vast majority of health services that we provided to patients, a firearms license - the existence of one - is entirely irrelevant information, and the Health Authority is concerned it would be a breach of patient privacy to provide this in a health record.

It's also important it could be a barrier to an individual seeking treatment, but I don't think it would be a stretch to suggest that some people would very jealously regard the privacy of that information that they hold a firearms license. And if they were concerned that showing up in an emergency department seeking treatment and care, whether for a mental health purpose or any purpose, is going to give rise to questions being asked, as everyone would be as to whether they hold a firearms license could be potentially problematic. We want more people seeking care, not fewer.

The important balancing of those interests that I've talked about a couple of times about personal health information and the need for the Health Authority to make sure it's acting consistently with those legislative dictates can be seen in a recent decision of the Office of the Information and Privacy Commissioner for Nova Scotia - OIPC. There was a recent 2021 decision, review report, of the Commissioner, the review officer,

and the citation for Your Honour is 2021 NSOIPC 07, and it's Review Report 2107. And I won't go into detail about it, but it involved a complainant who had completed a "driving while impaired" program which is a mandatory program that a persons need to go through where they've been convicted of an impaired driving offence. And the DWI program in Nova Scotia is administered through Nova Scotia Health and it's comprised of a standardized education component, optional referral to healthcare treatment, and a biopsychosocial assessment that results in an individualized risk rating. And, as part of that biopsychosocial assessment, it was required to collect information from collateral sources. And the individual involved complained that the administration of that program involved Nova Scotia Health collecting, using, and disclosing improperly his personal health information without authority. And it gave rise to an ultimate determination that Nova Scotia Health wasn't authorized to collect personal information about the complainant from collateral sources. It involved a fairly complex analysis of **PHIA** and **FOIPOP** ultimately did most of its analysis under **FOIPOP**, but essentially sanctioned or said the Health Authority was no longer able to collect information from collateral sources as a way of testing or considering what was being told about risk

factors.

So the conclusion said,

> In conclusion, this review raised, in a very complex way, how difficult it can be to balance competing privacy and public safety rights. The purpose and objectives of the DWI program are societally important, but, that being said, **FOIPOP** is clear that personal information can only be collected, used, and disclosed in accordance with its provisions.

So, again, not exactly the fact pattern we're dealing with, but it underscores the need to consider how any recommendations might emerge that ensures that it's consistent with those obligations set out in the legislative regimes of **PHIA** or **FOIPOP**.

The next recommendation from Ms. Miller's submission is at paragraph 35 and I think I've touched on that. It is the recommendation proposing a record access solution office. And, again, you've heard me say that while provision of an office with some individuals who would have information to assist healthcare providers or Nova Scotia patients in determining how to access those records is laudable, we do have an issue if that role were

to be expanded to become the gatherer - the middle person - in collecting those documents and those records.

The next recommendation I want to touch on, Your Honour, is at page 37 of Ms. Miller's submission, and it's a recommendation that says:

> The Health Authority and OSI Nova Scotia Mental Health intake and discharge records should include a mandatory section which requires consideration and summary of collateral information from family members with a specific requirement to consider and identify detail possibly relevant to family violence, suicide, or homicidal ideation.

And then a similar ... or a follow-up to that is a proposal that training be provided for all those who intersect with mental health care in relation to the importance of collateral family information, including a requirement to collect collateral information. And, with respect, it's important to recognize what can and can't be done, or what might potentially be counterproductive.

The question of whether collateral information is required in order to formulate a diagnosis and a case plan is based on

clinical judgment. It is information that is sought very often and it's important very often, but it is an exercise of clinical judgment by the mental health provider as to when and where to seek that information. In most cases, it usually is a good practice, or practical to obtain that information from collateral sources. We see that mental health nurse, Heather Wheaton, did just that in eliciting information from Shanna Desmond on October 24, 2016. So I'm not here saying that collateral information is unimportant. Very much, that is not the case. But mandating that clinicians must obtain collateral information is dictating care and is taking away the exercise of that clinical judgement.

(14:30)

Further, the recommendation talked about collecting that information in intake and discharge records. Intake has a very specific meaning in the healthcare context and the mental health care context because it really talks about that initial presentation, that initial touch between the Nova Scotian and the healthcare system. And in each year, some 21,000 mental health and addiction intakes are performed. But that intake is performed as the first step before a therapeutic relationship is established between a care provider and the patient.

If the information from collateral sources was required at

intake, it could act as a significant deterrent to certain persons seeking care, because there will be some individuals who do not want any information to be sought from others. Whether it's a concern of stigma with respect to mental health, which is reducing fortunately but still exists, or whether through any other reason there may be individuals who would not come and seek treatment and care if the concern was that information would be elicited and sought from collateral sources.

Now once a therapeutic relationship has been established, clearly there can be benefits in getting that collateral information and it's entirely appropriate that clinicians be afforded the opportunity to exercise their clinical judgement to determine when and how that information will be sourced. But, ultimately, that is also a decision that rests with the individual patient. Consent must be given.

And while some of the recommendations suggest that ... in certain of the presentations submit that privacy issues should be given lesser consideration, the reality is that the personal health information is that with the patient. And if they elect not to authorize information to be provided to a family member, then they can do so.

Now the Health Authority recognizes the benefit and the need

for that. They have transition plans when people are leaving services that talk about involving family and friends. So there's a recognition that there needs to be broader supports around. So I'm not sitting here suggesting that collateral information, either to help treatment in the moment or in the future is unimportant but it has to be an exercise in clinical judgement by the individual caregiver.

So we do have a concern with that recommendation that requires some form of mandatory collection of information from collateral sources, which would be contrary to a person's privacy rights and would be counterproductive in terms of delivery of good healthcare and ensuring that persons seek access when they need treatment and help.

The next recommendations are at page 40 of Ms. Miller's submission where she makes reference to pocket reference guides similar to the two exhibits that have been provided to the Court dealing with domestic violence issues or intimate partner violence issues, and a recommendation that similar guides be available for family physicians or emergency room physician or front-care health providers. And the Health Authority has no issue with information of that nature being available, but again you just have to be tailoring anything to a specific context and

view is that it's not necessary or practical for all front-line healthcare providers to be carrying such a document around with them.

But if there's summary information that can be available, it could be posted in a relevant position, a nursing station or a desk. So if there are reference guides that might flag referral sources or anything of that nature, then it could be available somewhere within the healthcare institution. But unlike police officers who would be traveling around with pockets to be carrying things in, the healthcare services are normally provided from the same physical location.

And a few additional comments on some of the additional recommendations. Last ones I'll cover are a few that Mr. Rodgers' written submission included on behalf of the Estate of Cpl. Desmond. And there was a recommendation that the Health Authority work with VAC on research regarding PTSD with dissociative disorder among combat soldiers. And there was another recommendation in relation to study or research that suggested that the Nova Scotia Health Authority should study the treatment of PTSD symptoms with medical marijuana.

The Nova Scotia Health Authority supports researchers within their institutions if they wish to pursue research in a specific

field, but the Health Authority doesn't force or dictate or control what researchers elect to research. So we have no ability or means to be doing anything as proposed in those recommendations.

There's a further recommendation Mr. Rodgers made that suggests there was no reason that patients seeking mental health support should be forced to be medically cleared in an Emergency Department before being seen by mental health services and suggested that there should be a separate emergency room for mental health. The Health Authority does not agree with those recommendations and thinks they would be counterproductive.

The Health Authority works to integrate and coordinate delivery of healthcare. Creating more silos would be inconsistent with that trend. And mental health challenges and issues don't operate separately of physical issues. The physical and mental health difficulties can overlap and patients should not have to choose which aspect of their health is worse at a moment in time when they enter an Emergency Department.

Mental health and physical health aren't watertight compartments and separating them would create more risk to patients. The Health Authority has considered the appropriate mechanism to be dealing with those presenting in Emergency

Departments and don't think it's practical or reasonable to try to separate ... create a separate emergency room or fail to ensure that there are no physical issues before access to any mental health services.

Your Honour, subject to any questions you have of those comments and the recommendations, those are all the comments I propose to make on the recommendations.

THE COURT: No. No, Mr. Rogers. I appreciate that I just thought I would engage in a couple of questions to help clarify my thinking on some things, so I very much appreciate your time and your explanations.

MR. ROGERS: Thanks. So I ... last conclusion, I, too, would like to thank Inquiry staff, to Elise Levangie and Selena Acker, and all the other staff behind the scenes that have allowed us to be here and in Guysborough. I very much appreciate it.

My thanks to Mr. Murray, Inquiry counsel, together with his colleague, Mr. Russell, who has moved on to bigger and better things and appreciative of the ability to work cooperatively with Inquiry counsel and appreciative of their collegiality and professionalism.

The events here, everyone has described as tragic, and they

absolutely are to anyone who's heard about these. It must be unimaginably difficult for the family and friends affected by this to experience not only the horrible events of early January 2017, but reliving it through all the evidence, and so we empathize with them.

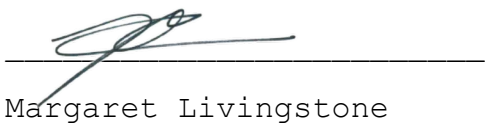
Mr. Murray, in his submissions, said that we're here to understand and learn and those are important words. And we look forward to the report and the recommendations of this Inquiry to help us understand and learn.

THE COURT: Thank you, Mr. Rogers. Thank you, Counsel. I think that brings us to the close, at least for the afternoon. We'll see you tomorrow morning at 9:30. Thank you.

COURT CLOSED (14:41 HRS)

CERTIFICATE OF COURT TRANSCRIBER

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



Margaret Livingstone

(Registration No. 2006-16)

Verbatim Inc.

DARTMOUTH, NOVA SCOTIA

April 22, 2022