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 20, 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.
Counsel for Dr. Faisal Rahman and Dr. Ian Slayter

INDEX

APRIL 20, 2022

COURT OPENED (09:31 hrs.)

THE COURT: Thank you. Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: We are going to continue this morning with oral submissions from counsel and others. Mr. Macdonald?

MR. MACDONALD: Thank you, Your Honour.

SUBMISSIONS BY MR. MACDONALD

MR. MACDONALD: Well, Your Honour, it has been a long two and a half years, of course, and it goes without saying, I guess, that I am Thomas Macdonald, lawyer for the Borden family, and Thomas Morehouse has ably assisted me throughout this process and these oral submissions will really supplement our written submissions, which we have already filed.

We wanted to start with some thanks, Your Honour, and of course, to you, to Mr. Murray, to Mr. Russell, now Judge Russell, to Ms. Levangie, to Ms. Acker, to the sheriffs, to the court staff, all of whom, to the people of Guysborough and Port Hawkesbury, who have always been so patient with all of us over this last time in this period. And we also, respectfully, want to thank and reach out to the Desmond sisters and their able counsel. I think it needs to be noted that without the advocacy and the persistence of the Desmond sisters in pushing for this Inquiry, no one would be here today. And if there is a legacy for their brother, the legacy of the fierce advocacy of his sisters for him is something that will last and for them to remember.

Your Honour, we know what the terms of reference say. We

all know as lawyers here that you're tasked with making findings and recommendations. And I tried to rephrase it another way in the brief, which is to say, I think it's what happened and why it happened and that's really in plain English with what you have been asked to do by the Minister. It looks like a daunting task at the beginning, at the opening, but our submission is that through the evidentiary framework that you have put in place, along with your team, Mr. Murray, Mr. Russell, through documents, through witnesses, and through expert witnesses, there is now a roadmap for you to follow, an evidentiary roadmap, to lead to the evidence that will help you in making findings and recommendations because the evidence was, perhaps people thought at times, exhaustive but it was very much a guiding star in terms of where to end up with this Inquiry.

We focussed on discreet areas in terms of the cause and the manner of death, domestic violence, firearms licensing issues, post-traumatic event, financial support for surviving family members.

There are many other issues. We acknowledge there are many other issues and other lawyers have dealt with that. You will deal with that. Witnesses have dealt with that. Whether it deals with PTSD, with members of the Forces leaving and

interacting with the Veterans Affairs support system, medical records and the ability of medical records systems to speak with one another and police records. So we acknowledge all of those other issues but we're focusing on what we look at as core issues.

So what happened and why, Your Honour. We think there is no other conclusion but to say that Mr. Desmond's actions were deliberate, they were planned, they were premeditated, they were homicidal, they amounted to domestic abuse and intimate partner violence, at least in terms of Aaliyah and Shanna.

That's not the Borden family just saying this in a vacuum or me. It's based on evidence and to get to that conclusion, we respectfully submit that there are key areas of evidence that must be looked at. One is the RCMP investigation. There is Dr. Rahman's evidence, there's Dr. Theriault's evidence, and there's Dr. Jaffe's evidence.

Now in terms of the RCMP investigation, and it was extensive, but we know that they've tracked that Mr. Desmond purchased a hunting knife, he purchased a firearm and ammunition, he was dressed in camouflage, he parked his vehicle on a side road, he slashed the tires on his wife's car. In the view of the RCMP officers, we know they're not Crown attorneys,

their view was had he lived, there would have been evidence to support a first degree murder charge. In other words, that this was a deliberate act.

Your Honour will recall you took Dr. Rahman, who was the last treating psychiatrist at St. Martha's to see Mr. Desmond, through the Leaves & Limbs Sporting Goods Store video when Mr. Desmond was there and he was purchasing the firearm and the ammunition. And Dr. Rahman, as a psychiatrist, testified that what he made of that was that Mr. Desmond was interacting with the clerk, he was making choices, he chose the firearm, he chose the ammunition, and he interacted with the clerk in terms of completing the transaction.

So all of those factors, in our submission, and not just ours but Dr. Rahman's view, are not consistent with someone who was disassociating or having a flashback, they were deliberate choices and wilful choices, if I could put it that way.

Dr. Theriault, of course, was an expert witness and he said in his evidence that Mr. Desmond knew what he was doing, his actions were intentional. He appreciated the nature and quality of his actions. He appreciated their consequences. He was angry. He knew what he did was wrong. And the defence of not criminally responsible would not have been available to him had

he survived.

Dr. Jaffe, of course, if not the leading expert on domestic violence in the country, he is one of them. He was here as an expert witness and qualified as such with the Inquiry. He believes this to have been an act of domestic violence, intimate partner violence, and much has been made of his view that it was predictable and preventable. I've heard my friend, Mr. Rogers, yesterday so eloquently on behalf of the Health Authority giving their view of predictability and preventability. Though it seems to us that we stand by what Dr. Jaffe said, we as in the Borden family, but that's not to point fingers. But when you are a specialist physician or nurse, or indeed a lawyer, what do people expect of you? They expect some kind of predictability, whether it's with a legal problem or a medical problem. Because you're trained to predict what an outcome may be. So I think that's a view that needs to be taken into account within the context of Dr. Jaffe's predictability and preventability philosophy, I guess, if we can put it that way.

(09:40)

It should not be lost in the topic of domestic violence that it's rampant in society but that three generations of African Nova Scotian women, and I put Aaliyah in the category

although she was a 10-year-old girl. Their lives were taken that day and that's a terrible thing and everybody, I think, there is no one who would not agree with that, and that's against the backdrop of this Inquiry. That those deaths, at least in terms of Aaliyah and Shanna, were the result of domestic violence. It may not be the type of textbook domestic violence that people think about, because it was a different kind, but it was sustained over many periods of time, a long period of time, and Dr. Jaffe's evidence was that even Shanna herself may not have known or appreciated the danger that both she and Aaliyah were in.

And we have Shanna as a strong black woman, well educated, recent graduate from St.F.X. in Nursing, an advocate for Lionel when they would visit the Emergency Department, but yet she didn't appreciate, in Dr. Jaffe's view, the extreme danger that she was in and, by extension, Aaliyah.

In terms of firearms, Your Honour, we are simply saying this. The purpose of this Inquiry is not to point fingers, we know that. But when you look at the information available in this case, in the New Brunswick Firearms office, through the police FIPs, Firearms Interest Police Reports, there was a lot of information that they had at their availability and they used

their discretion. We say they have the discretion, of course, to reinstate his license, and they did so. But when you think about some of the information that they had, Your Honour, contained in the FIPS, we would submit that there was more than information to exercise that discretion in a different way. To leave that license under suspension until they got more information and more medical reports. What was the information they had? He was ex-military with combat experience. He knew how to use firearms. He had PTSD. He was depressed. He was prescribed medical marijuana and had stopped taking medication. He had manic episodes. He had suicidal ideation. He had domestic problems rising to the level of police intervention and the seizure of his firearms. That was all information that was in possession of the Firearms Office in New Brunswick.

So they didn't speak with Shanna. You know, Mr. Roper testified that it wasn't out of the realm of possibility that he could have, I'm paraphrasing his evidence, but he didn't, chose not to. And so it was possible to keep that license reinstatement on hold, had they wanted to do so.

In terms of recommendations, the Borden family looks to Dr. Jaffe and his extensive recommendations and those eight recommendations and would be pleased if you were to recommend

that the Province adopt those but not adopt them in a vacuum. In other words, adopt them and break them out in terms of some recommendations that could be implemented very quickly. And so we heard suggestions of an implementation committee and a five-year mandate, all of those are, of course, laudable. But some things can be done, we would submit, more quickly. For example, the educational component of Dr. Jaffe's recommendations, whether it's a healthcare provider, whether it's public education, whether it's in the schools. If you see something, say something and make people aware when they're in a stressful situation, let's say, in a hospital, as Dr. Jaffe said in his evidence, perhaps take, in that case, Shanna aside and ask her, is she okay, do you understand that this may be going in a very bad direction, so that people maybe have some heightened sense of self-awareness.

With respect to recommendations in firearms, no one wants to take or put up barriers to keep firearms from hunters. So the outcry that may be felt across the country in terms of more firearms regulation should be tampered down with that in mind. But when you have a situation presenting like Mr. Desmond had, with all of those factors, for example, in the FIPs, then our submission is there needs to be a heightened level of awareness

throughout the firearms offices across the country, including this province, and we know it was not our firearms office that reinstated the license but nonetheless, to not hold back to trigger psychiatric intervention in terms of a report or a letter from a psychiatrist, a doctor, if someone presents with the Desmond factors, as I call them, which I will not repeat but they're the ones that I mentioned a few moments ago that are in the FIP. So that there's this extra level of review and a respectful reminder that no one is suggesting that firearms officer and chief firearms officers aren't trying to do the best job they can do given the amount of licenses and the amount of personnel they have. But having said that, a respectful reminder that they are not doctors. They are not psychologists. And so it's all the more important to lean on medical, psychological or psychiatric evidence, when necessary, not in every case, not in every application, but when necessary.

Mandatory contact with a spouse, an intimate partner of a firearms' applicant with those factors present to ascertain their position. So a call, a call on the phone. And when there are FIPs, have the applicant explain maybe in writing and orally, or both, the instance leading, giving rise to the FIPs and also what factors are present with respect to the FIPs to

explain those. There could be a checklist, not to be used on every application but to be used on those other level of applications.

I think, Your Honour, lastly, while there may not be direct evidence on this point, there was a sense that I had, at least, that there was pressure on the firearms office to process applications, to move them along. I am not saying they are cutting corners, but the point is, always, always, always safety of the public, safety of intimate partners, of course, needs to trump the perceived ability to be more efficient within a firearms office. So when they need to take a breath and get more information and speak to more people, they need to do it and that should always trump pushing an application through because the applicant seems like a good guy and he's okay now. Well, he's not okay now unless a doctor, and we would say in Mr. Desmond's case, a psychiatrist, should have said he's okay now in terms of that material before a firearms office.

Financial support, Your Honour. This is not, of course, something that you have within your jurisdiction but you do have the power to recommend. And Dr. Jaffe had agreed with the suggestion in terms of financial support for help with counselling and PTSD. We would say we agree with all of that

but we would take it a step further. And I don't think anyone, who is watching the livestream at home, who has followed this in the news, who lives in this province or any other province, who is in this room, can appreciate the living hell of the Borden family to live in ... Here we are, all these years later, living in the same space where four people were brutally killed. Living there everyday. Going to bed there, getting up there, going about their lives there as best they can, because they can't afford to move.

(09:50)

And so our submission is, frankly, this. If government can't help in those circumstances, when can government help? If government says black lives matter, isn't this an example right here in Guysborough County, and we're in, of course, Cape Breton today. But isn't this an example of how government could help should they want to. It's not about liability. It's not about admitting anything. It's about a caring government helping black Nova Scotians move on with their lives after a terrible tragedy. So we would simply say we know you don't have the jurisdiction to order that, Your Honour, but in terms of a recommendation, that may be something that could be looked at.

The last thing, Your Honour, is this. I mean your task is

broken into two parts, its findings and its recommendation. We live in a plain-speaking province. If you're on a wharf in Yarmouth County, or you're in Guysborough County, or in an office tower in Halifax, or you're in Cape Breton with its rich history in coal and steel, Nova Scotians are plain-speaking people. They want answers and they want to understand what happened and the why will come and the why could be more controversial in terms of the background, but the what is not. The what is follow the evidence. And so we would respectfully submit that, please, when you write your report in terms of the what, you say it in blunt language, it's not pleasant, it can be hurtful to some people. But it needs to be said so that every Nova Scotian, whether it's the day after your report is released, or a year after that, if they're stopped on the street and asked, What was the result of the Desmond Inquiry, maybe there will be some great recommendations that will be implemented by government. But they can say, Here is what happened because this is what Judge Zimmer said happened based on the evidence.

Your Honour, those are our submissions. Thank you.

THE COURT: Thank you, Mr. Macdonald. Thank you, Mr. Morehouse. Mr. Coward?

SUBMISSIONS BY MR. MACDONALD

MR. COWARD: Good morning, Your Honour. How are we this morning.

THE COURT: I'm fine, thank you. Yourself?

MR. COWARD: I'm very well, thank you.

SUBMISSIONS BY MR. COWARD

(09:53)

MR. COWARD: Your Honour, as you know, this is my oral testimony in the Lionel Desmond Fatality Inquiry on this 20th of April 2022. My name is Rubin Alexander Coward, CD, Canadian Decoration, and I'm a community advocate.

What I would like to do with your permission, Your Honour, I would like to begin by acknowledging my brothers and sisters of Mi'kma'ki, the ancestral and unseeded territory of Mi'kmaw people. This territory is covered by the Treaties of Peace and Friendship, which Mi'kmaw, Maliseet, and Passamaquoddy people first signed with the British Crown in 1726. The treaties did not deal with the surrender of the lands and resources but, in fact, recognized Mi'kmaw and Maliseet title and established the rules for what was to be an ongoing relationship between nations.

Quite frankly, Your honour, I hope that this honourable Inquiry is alive to some of the comments I am going to make today and I am going to ask that they would contextualize those comments.

I am going to begin by saying, following my attendance at this Inquiry back on the 24th of February of 2021 as per the

transcript, and my application to be granted an opportunity to present oral testimony, and your granting me to also file a legal brief at the conclusion of this undertaking. You directed me in a helpful manner to review your opening remarks on May 29th, 2019, which I wasn't present to hear.

Accordingly, I have carefully followed your direction and have carefully reviewed the transcript of your opening remarks heard in Guysborough on the 21st of May 2019, as per your suggestion. And with your permission, I would like to comment extensively on the Paris Treaty, which underscore your mandate, and then subsequently, your findings as noted at paragraph 3, subparas (a) through (d) and sub sub paras (i) through (vii) identified by Roman numerals, respectively.

However, Your Honour, I would like to point out that in forwarding my original presentation, you further provided me with direction as it relates to the terms of reference for this Inquiry, which I offer my thanks and appreciation to you, Your Honour. And I have since then revamped and revised my oral presentation that I might remain in cadence and adhere to the guidelines of the terms of reference accordingly. Thank you, Your Honour, for your guidance in this regard.

In my communications, Your Honour, with the Borden family,

I indicated that I would follow through on questions posed at paragraph three of the terms of reference to give them a better sense as to what went wrong, in my view, and the problems I found to be systemic in nature as it relates to BIPOC people obtaining proper attention from healthcare providers and medical attention from these institutions as it relates to this Inquiry.

With that being stated, I would like to shed some much needed light on the aforementioned Paris that are inextricably linked to Lionel and his family's ordeal and the resultant tragedy and the trauma associated with this matter.

However, prior to delving to the aforementioned subject matter, it is felt that my sharing why I became a community advocate may provide insight and be of assistance to this Inquiry.

In March of 1993, I was clinically diagnosed with post-traumatic stress disorder as result of the racism I suffered in the Canadian Armed Forces, specifically the Air Force. I was fortunate enough to ask university colleagues if they had knowledge of a black psychologist and/or psychiatrist.

A dear friend of mine, an university roommate of mine, we called him Gilbert Get Down Day, provided me with the name of a Mr. John Manning, a master practitioner, clinical counselling

therapist, whom I and my entire family have seen for some three years. Mr. Manning instructed me to do whatever I felt would be critical and crucial to my healing and regaining my image of self and sense of self since the significant trauma and injury to my family and I.

I want to say, if I may, Your Honour, that being a community advocate, it's not all glitter and gold and it's not an easy task. In fact, it's pretty arduous and it requires that we be alive to the feelings of those peoples, whether the person be a rape victim, sexually assaulted individual, somebody harassed horrendously, bullied. We have to remain alive to the sensitivities and the harm that has been done to those individuals. We are not in this, Your Honour, for photo ops or recommendations of accolades. We are in it because we want to try to save the lives of our families, friends, and those in the larger community, whether they live in Newfoundland or Vancouver Island. It's my endeavour as an advocate to my level best to try to be one of the members in the healing process. I'm not here today, Your Honour, to purport to be a psychologist, psychiatrist, social worker, sociologist, but I am here as an individual that has over 30 years' experience, not only as a PTSD survivor but having had the opportunity to deal and help

several people, and I'm going to get that further along in my oral presentation.

(10:00)

I will also share some of my experiences I've had in dealing and assisting injured persons and additionally, draw from the almost 30 years of experience I've garnered in my capacity as a community advocate having had the privilege and pleasure to work with well over 150 individuals suffering from sexual assault, rape, PTSD, complex PTSD and bipolar, to name but a few.

This Inquiry may contextualize my testimony to better understand the plight of injured military members who have acquired PTSD from a plethora of varying circumstances and, in particular, for greater clarification, the impact this malady has on BIPOC members like Lionel, that is clearly not understood nor taken seriously.

Accordingly, to give this Inquiry a sense of the magnitude of my advocacy, it is felt and important, in my view, to inform this Inquiry that as a community advocate I have advocated for seniors in the community who were ripped off by unscrupulous contractors; military members; members of police forces across Canada; federal government employees; provincial government

employees; the Women's Nova Correctional facility in Truro; RCMP officers across Canada; Correctional officers in Nova Scotia; filed complaints to the Nova Scotia Human Rights Commission followed up with legal briefs; participated in mediations; filed complaints to the Canadian Human Rights Commission and followed up with legal briefs; filed for judicial review with the Federal Court Trial Division. These are the many paths community advocacy have taken me over the course of the past 30 years.

As many of us, Your Honour, have followed this Fatality Inquiry, quite frankly, what has been absent from all of the professionals who came forward and gave testimony evidence is the fact that in addition to Lionel's tour in Afghanistan, absent and perplexing there was no mention made of the racism Lionel faced from fellow members of his unit at CFB Gagetown or whilst deployed in Afghanistan. Why not?

We have heard several experts in the field of trauma, psychiatrists and psychologists alike. Conversely, however, we have heard testimony from both Sheldon and Shonda Borden, Shanna's younger siblings, that that is precisely what Lionel was targeted for and subjected to in his home unit, racism.

With respect, Your Honour, I hope that it is understood that racism was and is a variable in the experiences Lionel

encountered in the military and that can be demonstrated that racism played a significant role in why Lionel and his family didn't receive the critical and crucial help they so badly needed that regrettably resulted in this tragedy and this Inquiry.

Today a heavy emphasis will be placed on Lionel and his family as it relates to the impact of trauma that it had on the family unit and what I've learned in almost 30 years of community advocacy, clinically diagnosed myself by more than five clinicians back in 1993 through 1997 with complex PTSD *inter alia*. As an expert in this field, let me first share my triage approach to assisting those who have solicited me for my services.

I begin by asking the injured person to bring their spouse or partner to our home when I first meet with them. I begin by attempting to make all present comfortable and generally ask about the children, how the drive was and then turn the conversation to the spouse or partner of the injured member. My questions are designed to extract just how the family unit is doing and coping.

I ask if they have a therapist or counselling of any sort. Normally, the answer is no, I or we don't. Then I ask the

spouse or partner how he or she is doing and coping. Nine times out of nine they burst into uncontrollable tears of hurt, confusion, heartache, pain and deep sorrow, what I anticipated, quite frankly because they have all been exposed to trauma by now. And even more troubling, they haven't had any help, counselling or assistance in dealing with their trauma.

I tell them I will get them the help they need and I will be the hope, with God's help, they will need to get through this. I am fortunate enough to have a few psychologists, psychiatrists, a master practitioner and clinical counselling therapists and a few law firms I can call upon to advance their healing and help.

Because when people with PTSD are listened to and informed about the process, they begin once again to believe that somebody actually cares if they live or die. That they are humanized again. This is extremely important and key to the PTSD member having a glimmer of hope again that actually somebody believes it. They are not going crazy nor are they crazy. What they are is injured and traumatized by their injuries.

Well, this is their reality. Without proper help and hope, these people perish. Have I seen it? Regrettably, yes. In

many of these severe circumstances I get permission to accompany them to their counselling sessions so that they don't feel alone. In fact, this is encouraged by some of the clinicians I deal with. Why? Because to the uninitiated, trauma produces the "crazies" for them because they have no idea what had happened, why they are so sad, angry, have bouts of rage, panic attacks, insomnia, recurring dreams that are devastating, headaches, take the drugs, drinking, gambling, sexual promiscuity, a sense of shame but they won't call it that.

At this stage, they're not even aware that shame has played a significant role in their current existence. Why? Because as my clinical counselling therapist informed me some 29 years ago, John Manning, who I refer to in fact as my angel. In my own instance, John shared with me that shame is too difficult to accept and acknowledge because it represents one's defeat. A sense of failure, not being accepted, ostracized, beaten down, to name but a few of the emotions associated with PTSD and complex PTSD.

Many are ashamed to ask for help, and if they do and no one listens this further rejection serves to re-trigger and re-traumatize the already wounded victim. Have I seen this happen in other cases I've dealt with? Yes, on a number of occasions

regrettably. What is key here and must be acknowledged is that these injured people are frail and like a crystal glass, if dropped they can easily fall or break into many pieces.

What I've explained above concerning Lionel I will assert is the danger in not properly addressing the concerns such wounded persons may present with, and sometimes the next rejection sends them into an abyss that they cannot escape from or return. PTSD is very complex because the very sense of self has been destroyed.

The following excerpt, I believe, clearly explains the extremely severe impact of PTSD and trauma. It is very interesting to note that on the 19th of December 2019, Veterans Affairs Canada now have acknowledged and recognized that for first line responders, the RCMP and military members that acquired PTSD and/or complex PTSD it affects the member, the family and the community.

(10:10)

In my view, this acknowledgement is very important in underscoring and understanding the significant and pervasive damage that PTSD has on a larger segment of our society, the community and the family members. An example of the proactive measures that were taken by the government officials of Sydney,

Cape Breton back in 1991. After the brutal murders at McDonald's in Sydney River, they unanimously decided to tear down that structure, the McDonald's down, in an effort to aid the families, friends and the community to begin the healing process. Which brings me to the most disturbing segment in this unfortunate tragedy.

Other members of the community and I in tandem, have solicited the Government of Nova Scotia, Veterans Affairs Canada, politicians, the Minister of National Defence, the Minister of Veterans Affairs, the Prime Minister, to name but a few, in an effort to have Thelma and Ricky Borden and family moved from the home where the tragedy took place more than five years ago now. Regrettably, none of the parties solicited offered any response or action to mitigate the continued trauma Thelma and Ricky Borden continue to endure. In my view, ignoring this condition is both cruel and callous, for we understand full well that no one can heal in the environment where the trauma took place.

Therefore, Your Honour, I would humbly ask that you explore this further in your determinations and in your recommendations subsequent to the close of this Inquiry, that the families may begin to heal. And if I may, I will piggyback on Mr. Thomas

Macdonald's comments earlier where I realize, Your Honour, that this is not really within your purview, but certainly, Your Honour, as the presiding judge in this Fatality Inquiry your words have merit and measure. And I would humbly ask Your Honour that with the blessings of this Inquiry that you would move forward in an expeditious manner so that we can all help in assisting the family so that they too can begin to heal.

In my humble opinion, the recent comments in Halifax, Nova Scotia in **The Chronicle Herald** on the 31st of January 2019, they were made by the Honourable Chief Justice Michael J. MacDonald might help us to understand and explain difficulties and the plight of BIPOC people both here and right across this country when he commented the following. He said that: "Systemic racism exists in this province. I think for white people racism may be viewed as a concept, for African-Nova Scotians it is something they face, it's trauma." Certainly, with respect, the Honorable retired Chief Justice Michael MacDonald understands and he gets it.

A similar comment, Your Honour, was made albeit in a family law context. It was noted in Nova Scotia's **Ministry of Community Services v. S.M.S.** back in 1992 at para 91, and it states: "Racism is a pernicious reality. The issue of racism

existing in Nova Scotia has been well documented in the Marshall Inquiry. A person would have to be stupid, complacent or ignorant not to acknowledge its presence not only individually but also systemically and institutionally."

The remarks of the former Honourable Chief Justice as well as the Court in **S.M.S.** transcend the Province of Nova Scotia and are applicable to Nova Scotia and are applicable to this country. Absent experience of trauma, it is extremely difficult for the uninitiated to imagine the hardships and inter-generational trauma that racism causes the victims and their family.

And I want to go a little further, if I may, with the Court's permission ... your permission in particular, Your Honour. I ascribe this, regardless of race, creed or colour. If an individual sustains rape or sexual assault or bullying or harassment, again I would suggest we have to be mindful and we have to be live to those realistic feelings that those people are exhibiting and not fully cognizant of the magnitude of the damage that they have sustained.

Your Honour, it is precisely why I wish to highlight and expound upon this here today, trauma and the ultra-negative impact it has on the entire unit. Let me explain why I am

fortunate enough to be here today and Lionel and his family are not. It involves proper clinical counseling therapy by the right clinicians.

I've written incessantly since back in 1990 or thereabouts in an effort to better understand what was going on within myself. I came across a book in 1994 by Aphrodite Matsakis, a PhD and a clinical therapist at the Veterans Affairs Hospital in Virginia, and she published a book and it's entitled **I Can't Get Over It: A Handbook for Trauma Survivors**.

So in addition to the invaluable information I acquired from Mr. John Manning, I learned this valuable lesson from Ms. Matsakis and it's called de-personalization in trauma. During trauma you are subject to a process called de-personalization. De-personalization refers to the stripping away of your personhood, your individuality and your humanity. The sentence of being de-personalized or de-humanized is especially strong when the injuries sustained or the wounding, end or death witnessed seem senseless or preventable.

Dr. Matsakis goes further in describing the following:

> Trauma changes personality, not the other way around. It doesn't matter how strong you are, anyone subjected to enough stress,

> harassment or bullying can develop PTSD. More (where she continues) if you suspect that you are suffering from PTSD or you're suffering from PTSD don't be alarmed, PTSD is an extremely normal reaction to an abnormal amount of stress. Having PTSD does not mean you are mentally ill nor does it mean that you were weak or somehow deficient. The rupture can be so profound that try as you may you just can't get over it.

The Diagnostic and Statistical Manual Volume 5, the DSM-V, which is the psychologist and psychiatrists' bible has 300 medical conditions listed; however, PTSD and complex PTSD and bipolar disorder are the only three medical conditions that make it unequivocally clear that there is nothing wrong with the individual, and subjected to enough stress, harm, harassment *inter alia* this condition is caused by external forces. In other words, there's nothing wrong with the individual, something externally to them has troubled them to the extent that they are now traumatized.

In my view, this is extremely important for clinicians in

their approach to addressing and treating these conditions in patients, and in particular BIPOC patients. You see, complex PTSD and PTSD are not only caused by war, racism is a war BIPOC people are fighting and no weapon seemingly can successfully combat it without a change in the toxic culture in which it exists in every segment of our society.

Therefore, treatment of people of colour for racism should, where possible, be carried out by BIPOC initiatives because they are equipped with trauma informed care and are culturally competent and sensitive to the fragile condition of such victims. Why? Because these individuals once traumatized have lost their ability to trust anyone and, in particular, anyone that resembles the perpetrators; in other words, being white.

Wounded persons are hyper-vigilant and may present as paranoid to the uninitiated. Meanwhile, they are merely reacting and within the confines of their experienced traumatic experience or experiences. This is quite normal.

And for me as a community advocate patience is a key component in dealing effectively and efficiently with these wounded members. One is required to be an excellent listener and be prepared to restate answers to their questions and their concerns many times over the years you may be involved with

them. This, however, is consistent with what Dr. Matsakis describes in her book I mentioned earlier. She cautions us to be mindful of the following.

(10:20)

Due to the nature of their injuries they often will present with gaps in memory. This is a defensive mechanism of the brain designed to prevent them from sustaining re-triggering and re-traumatization from the initial injury and circumstances. It is also of paramount importance to underscore that trauma affects and impacts three essential components of the brain, the amygdala, hippocampus and the pre-frontal cortex. This is of significant importance as these parts play a part in regulating emotions and responding to fears.

And if I may, Your Honour, just to break this down in simplistic terms, it's like having a light switch on and off. Somebody with PTSD - it was explained to me by several psychologists and psychiatrists - that what happens is if they're not properly medicated the "fight or flight", that switch is on. And if they, over time, don't get the proper medication, that morphs into paranoia. It may morph into schizophrenia. It may morph into rages of anger because they have no idea what's going on.

So it's imperative for somebody that is diagnosed and that diagnosis, it's also imperative, Your Honour, that as soon as those conditions are aware or it's brought to their knowledge that somebody is suffering, it's imperative that not only to be diagnosed properly but they be medicated so that they can start to at least rest before they begin to heal.

You may be aware of the works of Frantz Omar Fanon, also known as Ibrahim Frantz Fanon who was a French West Indian psychiatrist and a political philosopher from the French Colony of Martinique. In fact, his works have become influential in the field of post-colonial studies, clinical theory in Marxism.

Frantz Fanon's theory of cognitive dissidents, as he explained, occurs when people hold a belief that is very strong and when they are presented with evidence that works against that belief, the new evidence cannot be accepted, so they would rationalize, ignore or even deny anything that doesn't fit with that core belief.

An example of that, Your Honour, I've spoken with women that have been traumatized and BIPOC people that have been traumatized and some of the abusers have said to them, Oh, you speak well. As if speaking well is an aberration. We're not in Persia so we don't have to speak Farsi, we speak English. And

so I believe that's the core of what Mr. Fanon is alluding to, that the stereotypical views held of people of colour over the past 310 or 15 years have been such that we come to not anticipate or expect. Our expectations of people ... BIPOC people, are in the lower percentile and oppression seems to be a variable in that equation to try to keep us at the very bottom of the socioeconomic scale.

I will assert that these very misguided beliefs are central to the systemic racism in institutional discrimination that Lionel and his family faced and that essentially led to his demise and that of his entire family.

In fact, in my 30 years of dealing with all peoples who presented with complex PTSD and/or PTSD, the most important aspect of my intervention was first and foremost is to ensure they were referred immediately to clinical counselling therapists for two primary reasons.

One, to have them properly diagnosed and the proper diagnosis would ensure they and their families receive the proper treatment they so urgently required to begin the healing process. That it would facilitate their knowing that they had help and that would lend significant support to the hope I could provide through demonstrating my abilities to listen, to hear,

show compassion, empathy, showing them love, and administratively moving their concerns forward now in a very proactive fashion that would help them once again understand and know that someone does care about them, their circumstances and their family unit. This is what hope looks like after the requisite help is provided.

In response to para 3, Your Honour, that you have been tasked by this government, the Attorney General in particular, I would like to respond to those paragraphs on behalf of the Borden family if I may. It's very important that we revisit this so that the Desmond family haven't died in vain. Lessons have been learned and that will be hopefully implemented immediately to prevent such a preventable tragedy doing forward.

At para 3, Your Honour, of your opening remarks and your transcript it says that the judge appointed to conduct the inquiry shall make and file with the Provincial Court a written report containing any findings made by the judge as to (a) the date, time and place of death. The entire family died on the 3rd of January, 2017.

(b) the cause of death. The cause of death was homicide and suicide. The manner of death. Gunshot wounds and trauma was the manner in which they died. And (d) the circumstances

under which the deaths occurred. In my view, negligence by the CAF, Canadian Armed Forces, Veterans Affairs Canada and civilian health providers in St. Martha's Hospital utterly failed to recognize the confused and depressed state of a person who was clinically diagnosed with the following: complex PTSD, paranoia, insomnia, major depressive mood disorder, adjustment disorder with depressed mood, and a lot more. Clearly, they lacked trauma-informed here and cultural competency as it relates to BIPOC people, because these institutions by their very design and composition are systemically racist and institutionally discriminatory. Is this any surprise to me? No. This is the trajectory of their circumstances when left unaided.

Roman numeral (ii) "Whether Lionel Desmond had access to appropriate medical health services, including treatment for occupational stress injuries." Lionel was precluded to access or to accessing the appropriate medical services, including treatment for occupational stress, injuries and racism. What is most disturbing to me is that when healthcare facilities are unwilling to name the injury in this instance as well as occupational stress and the consequence of occupational stress led, in my view, to domestic violence because all of these things going on that he had no control of, it doesn't become

part of the triage application to addressing these very real concerns and trauma.

In fact, his entire family were precluded from accessing the appropriate mental health services that a competent review of my case and circumstances would have revealed that it would have been, in my view, life saving.

Number three of the Roman numerals: "Whether Lionel Desmond and his family had access to the appropriate domestic violence intervention services." I will submit that Lionel and his family did not access appropriate domestic violence intervention services because all of the powers that be lacked trauma formed care and cultural competency. And rather than treating the initial traumas, Afghanistan and racism, these traumas were allowed to grow into a soldier who had no previous history of domestic violence prior to his introduction to war in Afghanistan. This is of paramount importance in correctly identifying the contributing factors rather than attempting to foist this on this injured soldier.

I have heard evidence from Thelma, from Ricky Borden, from George Borden, from Sheldon Borden, from Shonda Borden who all spoke glowingly about the love Lionel showered both Shanna and Aaliyah with, yet this is absent in the overall assessment.

Why?

Lionel was a great dancer, funny as heck, was an outstanding athlete and loved spending time with his family. In fact, Sheldon gave testimony that he had completed his high school year in Oromocto or Gagetown with Lionel and Shanna. He offered no account of an abusive relationship between Lionel and Shanna. What we do have, however, is a soldier who demonstrated love and devoted himself to his family prior to his injuries. But he was never given any chance to heal because he had not been provided with the necessary and professional help he so desperately needed to regain a sense of self.

(10:30)

Four in the Roman numerals. Whether health care and social services providers who interacted with Lionel Desmond were trained to recognize the symptoms of occupational stress, injuries, or domestic violence. I will submit that Lionel was not the first person to return from war with the above-noted injuries.

The real question that must be addressed and tackled here is how many other soldiers and, in particular, BIPOC members have also not received or been provided with appropriate access to the facilities that are supposed to help these people and

their families in the healing process. And while knowledge is purportedly power, I contend it is the application of that knowledge that is truly power. We have learned that seven of Lionel's members from his platoon also committed suicide on their return from Afghanistan.

So, Your Honour, it's clear to all of us that there's a bigger problem here that meets the eye. And oftentimes, as I've been told by psychiatrists and psychologists that I've been dealing with over the last 30 years, when most people have PTSD, they internalize because they figure something is wrong with them. And I was one of those victims. I internalized. I said, What's the matter with me? But there was nothing the matter with me. It was the circumstances that I was compelled to operate under that had driven me to that unreasonable reasoning.

Furthermore, I would suggest none of these soldiers were in their right minds because we didn't encounter what they endured or witnessed. Moreover, where there exists the toxic culture in health services, their knowledge is not ordinarily extended to aid BIPOC members. Accordingly, there needs to be a change in the toxic culture if BIPOC members are to ever see a paradigm shift in this meager-minded exclusionary practice. We call it simply systemic racism and institutional discrimination.

SUBMISSIONS BY MR. COWARD

The question is is there's systemic racism in the Nova Scotia health industry. The Nova Scotia Health Report is blunt. The report is available for all to read. Just a few months before he was dismissed from his post by the incoming Tory government, then CEO, Brendan Carr delivered a report called "Addressing Injustice within the Nova Scotia Health". Carr's report identified stories of racism. Dr. Barbara Heron (sp?), a Critical Care and Internal Medicine physician who also teaches at Dalhousie University Medical School, said having such problems highlighted for healthcare leaders at the highest levels means it's in front of people who needs to hear it.

Your Honour, in my view, it can't be overstated that if systemic racism exists within the framework of our healthcare system by racially-visible persons/colleagues, where would someone like Lionel expect to get a fair shake? I will submit he wouldn't and he didn't.

I will further assert that Lionel was a victim of systemic racism at each and every institution he went to seek help for his injuries and, accordingly, we cannot and must not attempt to mitigate his plight by trying to ascribe blame on the victim. This would be insult to injury that the family and community has already suffered.

Five of your report, Your Honour. Given Nova Scotia's administration of the Canadian Firearms Program, whether Lionel Desmond should have been able to retain or obtain a license enabling him to obtain or purchase a firearm. In my view, under no circumstances should any individual that presented with the plethora of injuries Lionel occasioned should have been given or granted access to any sort of weapon. This is simply common sense.

At six (vi), What restrictions, if any, apply to accessing federal health records of Lionel Desmond by provincial health authorities or personnel? I cannot for a certainty and accurately identify what restrictions, if any, apply to accessing federal health records of Lionel Desmond by provincial health authorities or personnel. But I will submit if this country is willing to send members of the military in harm's way, they damn well should have enough sense to help and assist them when they return and if they return, because we are aware that they didn't go on a picnic. All these levels of government utterly failed the entire Desmond and Borden family.

And seven, any recommendations of the judge about the foregoing matters. Your Honour, I make the suggestion with the greatest deference that we, as a society, must find a way and

work collaboratively to change the very toxic culture in which we all find ourselves dealing with and in. We cannot and should not shrink from doing what is right and just, that all human beings be treated with dignity and respect so that the hollow words of diversity, equality, and inclusivity are made manifest and not just comfortable slogans to maintain the status quo.

I will suggest that our proactive actions now will serve to help us all well and the future generations that will follow us. Let us ... let that be our resounding legacy, that we may demonstrate to the world how to treat each other.

All of the above is humbly submitted for your consideration as you see fit and just, Your Honour.

And, finally, if I may, on behalf of the Desmonds, the Borden families, members, friends, and the community, it is my sincerest hope that we may wisely put the lessons learned from this significant tragedy into action, that we may never have to convene a fatality inquiry of this magnitude ever again. Thank you, Your Honour.

THE COURT: Mr. Coward, thank you for your submissions and thank you for your service.

MR. COWARD: Thank you, Your Honour.

THE COURT: Ms. MacGregor?

SUBMISSIONS BY MS. MACGREGOR

(10:38)

MS. MACGREGOR: Thank you, Your Honour.

We provided written submissions, as you know, on behalf of a number of the physicians who testified in this Inquiry. We rely upon those submissions and we don't intend to repeat those for you today but we do wish to highlight a few key aspects of those. A significant issue explored later in this Inquiry has been the issue of domestic violence and it's in that respect, Your Honour, which we wish to offer a few brief comments.

The first is the fact that psychiatrists are not therapists. This Inquiry heard evidence that the role of a psychiatrist is generally to see patients once, to make a diagnosis, and to recommend medications and therapy if needed. The ongoing medical care is provided by the family doctor and therapy, if necessary, is provided by a therapist.

It is within therapy, or through a social worker, that issues of domestic violence may be more fully explored and addressed. For example, while at Ste. Anne's Hospital in Quebec, Dr. Ouellette specifically asked the social worker, Kama Hamilton, to contact Shanna Desmond to get us a better picture of what's happening at home, to see what her concerns were for

her partner.

(10:40)

Ms. Hamilton testified in this Inquiry and I quote, "In this case specifically, it has been prompted by the realization that I wasn't getting all of the information about the dynamics, about what was happening within the relationship." She stated that it was additionally important because she felt she needed more information to understand what was going on with the family. And she stated, "I was exploring that area on behalf of Dr. Ouellette. My primary ... my focus was just getting a bigger picture of what was going on with the couple." Your Honour, this is an example of care providers seeking to consider more beyond the immediate psychiatric issues and more beyond the concern for possible physical violence.

Dr. Rahman, who saw Cpl. Desmond at St. Martha's Hospital in Antigonish, appreciated that domestic violence may take many forms such as physical, emotional, verbal abuse, and financial abuse. While Dr. Rahman appreciated these aspects of domestic violence, he restricted his questioning in the Emergency Department setting to the issue of physical violence. This is in line with the evidence of the Inquiry expert, Dr. Scott Theriault, who testified that in the emergency room setting, a

psychiatrist is making a focused assessment.

Dr. Rahman noticed that Cpl. Desmond planned to see Dr. Slayter and his therapist, Cathrine Chambers, in followup. Given the nature of therapy, it is in that setting that the issues of domestic violence could have been explored more fully.

Importantly, the Inquiry did not hear from any physician expert that was critical of the medical care provided. Rather, Dr. Rahman and Dr. Slayter both highlighted the opportunity for further training for psychiatrists into the issue of domestic violence but in terms of resources, noted the need is for therapists on the ground. Dr. Slayter stated during his testimony, "If I had a choice, I would add ten new therapists to the public system because that's where the need is."

In conclusion, Your Honour, we just echo the comments of my colleagues in thanking yourself, the court staff, and fellow counsel for their work. And we echo the comments of other counsel, as well, in extending our sympathies to the Desmond and Borden families. We look forward to your report. Thank you.

THE COURT: Thank you, Ms. MacGregor.

Ms. Miller, are you ready or we can take ...

MR. MILLER: Perhaps if we can take just a five, ten-minute ...

THE COURT: All right. Thank you.

MR. MILLER: ... Your Honour.

THE COURT: So, originally, we had planned on a morning session and an afternoon session today. We had a brief discussion yesterday and we think that we can continue right through the morning and then maybe extend it a little bit and hear from the remaining individuals this morning, as well. So we'll hear from Ms. Miller, then we'll hear from Mr. Rodgers, I take it?

We'll take a 15-minute break or thereabouts. Thank you.

COURT RECESSED (10:43 HRS)

COURT RESUMED (11:04 HRS)

THE COURT: Ms. Miller?

SUBMISSIONS BY MS. MILLER

MS. MILLER: Thank you, Your Honour.

As you know, I represent Brenda Desmond and I share representation of Aaliyah Desmond with my friends, Mr. Macdonald and Mr. Morehouse. Of course, Brenda Desmond and Aaliyah Desmond were Cpl. Desmond's mother and daughter. My client, their personal representative, is Chantel Desmond and she is one of Cpl. Desmond's four sisters. My role, Your Honour, at this Inquiry was to represent family and, in this context, it was a military family.

When the men and women of the Canadian Forces leave their families, their homes, and our country to deploy to combat zones, they and their families know the risks of the battle ahead of them. And when they return to Canada, they reasonably believe the battle has ended as they are coming home to safety. But this is often not the case. Leaving the physical battlefield behind does not always mean leaving the battle, and bringing the battle home to Canada means family members on home soil are inevitably caught in the crossfire of a battle they know very little about as they do their best to assist and support their loved ones, readjust from the military theatre and

the horrors of war which accompany it. Family members know something is different and wrong with their loved ones, but they struggle themselves to understand what has happened. The impact on family members is very real. They need their own support through this time and often don't receive it.

The horrors of war run deep, with the consequences suffered for generations. Post-traumatic stress disorder, anxiety, depression, largely invisible illnesses broadly known as "operational stress injuries", are a result of occupational trauma experienced in the theatre of war which soldiers bring home with them. The impact of operational stress injuries is a societal one and one that we don't have a good understanding of, but we see the effects of on our military members, our veterans, and their loved ones. This was the experience of the Desmond family.

As Cpl. Lionel Desmond battled to live with the legacy of the occupational trauma he experienced in Afghanistan, his family battled along with him. Aaliyah, Brenda, and Shanna Desmond were the innocent and unintended victims of a war that impacted them daily after his return home and for which they paid the ultimate price. Cpl. Desmond was aware of his descent into the darkness of mental health struggles and the impact on

his family. He wanted to do better but needed help to do so. He struggled to find that help.

This Inquiry has dealt with difficult truths as it has explored if and how Cpl. Desmond, Aaliyah, Brenda, and Shanna's deaths could reasonably have been prevented and the issues mandated in the February 14th, 2018, ministerial order. After 53 days of evidence, almost 400 exhibits, and evidence from over 70 witnesses, we all now have a much deeper understanding of the battle veterans and their families face after returning home from combat with operational stress injuries and adjusting to all facets of civilian life in Nova Scotia. This includes navigating the public health care system.

We believe, Your Honour, it is clear from the evidence that these deaths were preventable, and it also appears from the evidence that these deaths were the tragic result of the combination of failures of multiple service providers and institutions at both the provincial and federal levels to share, consider, and/or action meaningful information in a timely way, or at all, to provide mental health treatment to Cpl. Desmond in a culturally-responsive manner, and in a manner to prevent system harm, and to identify and address signs of intimate partner violence. I use the word "failure" purposefully.

"Failure" is defined as the omission of an expected or required action, of not meeting a desirable or intended objective. Our submissions will address these failures along with suggested recommendations included in our written submissions for Your Honour to consider moving forward.

It was foreseeable that Cpl. Desmond was going to need ongoing and comprehensive mental health treatment following his release from the Canadian Armed Forces. The severity of his PTSD diagnosis and expectation that it would be a lifelong issue for him was ultimately what led to his release from the Forces in June of 2015. His Forces-treating psychiatrist, Dr. Joshi, identified that any major life situation would likely result in him decompensating.

As he got ready to leave the military, Cpl. Desmond completed, like all releasing members do, a risk assessment and transition interview. That took place on May 25th, 2015, and it identified him as a moderate risk for unsuccessful re-establishment and/or transition to civilian life. His score was such that the need for a case manager was identified as of May 25th, 2015. He, himself, rated his mental emotional health as poor; he rated his physical health as fair, noting chronic back pain, which sometimes impacted his ability to complete daily

tasks; and he also noted falling on his head when jumping out of a plane; as a result, having trouble remembering things and retaining information, but never being given a diagnosis. That was in May of 2015.

(11:10)

With foreshadowing of the future ahead, Cpl. Desmond noted that while married with a daughter, his spouse and child had moved to Nova Scotia some time before while he "tries to get better." He reported being very upset about this and believed the situation did not look good. It was with this background Cpl. Desmond left the Forces and began his transition to civilian life. As predicted in the risk assessment and transition interview and as demonstrated by the evidence, his transition was very challenging. Despite the foreseeability of his need for extensive mental health treatment, and despite being ensconced in the Veterans Affairs system, Cpl. Desmond found himself seeking help from mental health providers. This was particularly so following his discharge from Ste. Anne's in August of 2016 and in the last four months of his life.

The Nova Scotia healthcare providers who saw Cpl. Desmond in this window of time were significantly restricted because they did not have access to all, or any really, meaningful

information which would've helped to convey and understand the complexity and longevity of his mental health problems and/or to appropriately assess him for suicide and domestic violence risk factors. Without these records, none of the Nova Scotia healthcare providers were set up for success in treating Cpl. Desmond.

A compounding problem was that when a record did exist, it either did not canvass or consider what we say was highly relevant information which included collateral information from family sources. And I'll talk about that later in more detail. If collateral information was obtained from family members, it was not retained in a manner which made it possible to preserve that information for the benefit and consideration of future treatment providers. When information, collateral or otherwise, did exist, there seemed to be a focus on process over substance when it came to consent forms and sharing information among service providers giving privacy concerns. And I'll address that in more detail later as well.

Many health professionals who gave evidence confirmed that having complete and historical information relating to Cpl. Desmond's extensive mental health history would've been helpful. However, given the volume of information, not all information

was equally relevant and helpful. Our forensic psychiatrist, Dr. Theriault, was helpful on this point, addressing the issue of what constituted relevant information, by noting that information is useful, but it also has to be meaningful. Dr. Theriault identified meaningful information to include detail relating to the chronicity of problems Cpl. Desmond had, what symptoms were paramount and most prominent, and issues relating to his social environment, including the stability of housing and financing, these social determinants of health. He was also of the view that meaningful information included collaboration with Cpl. Desmond's wife.

Tragedies like this are never the result of any one thing or any one person. I will speak in detail about these consistent themes about the lack of sharing, collecting, considering, and actioning relevant and meaningful information between multiple service providers. Your Honour, the focus on this detail is not to shame or lay blame, but is context to ground consideration for recommendations as this detail of what happened in this situation highlights opportunities for this Inquiry and Your Honour to make existing systems enhanced and more robust.

We heard, and we understand from the exhibits, Cpl. Desmond

amassed a significant amount of medical information following his September 11th diagnosis of PTSD. However, very little of it was shared with and among treatment providers to follow. This is where I will touch on the specific examples, Your Honour, of failures to share meaningful information.

The lack of sharing meaningful and relevant treatment records set up treatment providers for failure. And, as I noted, the Inquiry heard over and over from these people that there would've been value in having more relevant detail about Cpl. Desmond's complex mental health history.

While the Inquiry has heard multiple examples of the failure to share meaningful information, there are three key items I'm going to highlight stemming from his time at Ste. Anne's. Those include the discharge summary, collateral family information, and diagnosis information.

The discharge summary was perhaps the most meaningful summary available addressing Cpl. Desmond's mental health challenges. It included recommendations for his future care, including the neuropsych assessment and the clinical care manager. Although dated August the 17th, 2016, the discharge summary did not make its way out of Ste. Anne's until it was completed on October 4th. We know that that summary was

forwarded by fax on October 7th, 2016, to his New Brunswick OSI psychologist. There is no evidence that it went anywhere after that. Certainly, the OSI Nova Scotia Clinic did not receive it, nor did Cpl. Desmond or any of his treatment providers in Nova Scotia. The valuable information in that document was never accessed by those in Nova Scotia who were in the best position to assist him that point moving forward.

Secondly, Ste. Anne's also failed to share meaningful collateral information obtained from Shanna Desmond. We heard that Ste. Anne's had unfettered access to Cpl. Desmond's wife. She was very candid with information and the concerns she had, providing great detail which should have raised red flags. Ste. Anne's social worker, Kama Hamilton, spoke with Shanna by phone on three occasions. Shanna's concerns with Cpl. Desmond's volatility and its disruptive impact on her and Aaliyah were relayed in each of those conversations. As his stay at Ste. Anne's was coming to an end, Ms. Hamilton spoke with Shanna on August the 12th when she shared her increasing concerns about his paranoia and anger towards her. Ms. Hamilton identified they could benefit from couples therapy. None of this information went anywhere. The August 9th telephone case conference between Ste. Anne's staff, Cpl. Desmond's VAC case

manager, and Dr. Murgatroyd from the OSI New Brunswick, had already taken place by the date of the August 12th call between Shanna and Ms. Hamilton. The discharge report contained none of this information, nor did it contain the recommendation for couples therapy. As a result, it appears none of this information made its way out of Ste. Anne's, nor was it preserved in a manner such that treatment providers after Ste. Anne's had any access or benefit from it.

The third example of additional relevant and meaningful information from Cpl. Desmond's Ste. Anne's admission that was never shared with anyone outside of that facility is as it relates to some of his mental health diagnoses. Ste. Anne's psychiatrist, Dr. Ouellette, appears to have been the first individual to diagnose Cpl. Desmond with mixed personality traits in his May 31st, 2016, report contained within the Ste. Anne's file material. Dr. Ouellette did not provide any content for the discharge report from Ste. Anne's, and the evidence strongly suggests that his May 31st, 2016, report was never provided to any external healthcare providers.

We heard evidence that, once completed, the discharge report, a closing note from the general doctor and from the psychiatrist were to have been transmitted back to the referring

agency; in this case, OSI New Brunswick. While Ste. Anne's did fax material to the New Brunswick OSI office on October the 7th, the OSI New Brunswick records at Exhibit 244, page 84, show no material was included from Dr. Ouellette. The conclusion is that medical records from the first and only person to provide a diagnosis of mixed personality traits was never shared outside of Ste. Anne's.

Another example of a failure to share meaningful diagnostic information from Ste. Anne's relates to psychologist, Dr. Isabelle Gagnon. She participated in the drafting of the discharge report as it pertained to her expertise, but she also authored two further reports dated November 27th, 2016, and that included a psychological evaluation report and a closing note. She identified borderline personality traits as a provisional diagnostic impression in her psychological evaluation report. However, there is no evidence, Your Honour, that these two November reports were ever shared outside of Ste. Anne's.

Continuing to deal with the lack of sharing of information, I move now to Nova Scotia where, even when records did exist in some cases, there were various system-designed barriers to sharing his available Nova Scotia records among the Health Authority medical providers. We heard that Nova Scotia has a

complex and complicated record-sharing system which does not lend itself to ease of access. Complicating the technology around this system are privacy issues.

(11:20)

Let me be clear. It is acknowledged that privacy concerns are valid. The Attorney General of Canada and the Nova Scotia Health Authority have addressed the limits of privacy that Inquiry recommendations will need to work within. However, and as noted by the Health Authority in their written submissions at paragraphs 152 and 153, the concept of circle of care does allow for the sharing of records without consent forms. And I'm going to read, Your Honour, from those paragraphs in my friend's brief. Paragraph 152:

> Generally, the **Personal Health Information Act** sets out the circumstances in which custodians may share information with other healthcare providers. Certainly, with the expressed and written consent of the patient, information may be shared with other providers. Additionally, health records may be shared interprovincially between health professions if they are in

the same circle of care for the illness or injury in question. The term 'circle of care' is defined in Industry Canada guidelines for the health sectors as follows:

> Individuals and activities relating to the care and treatment of a patient, thus it covers the healthcare providers who deliver care and services for the primary therapeutic benefit of the patient and it covers related activities such as laboratory work and professional or case consultation with other healthcare providers.

It is our submission that this circle of care perhaps is interpreted too closely and it needs to be expanded. And I'll give you an example of how that may have come into play, as I move forward, to deal with private healthcare providers and issues that they found accessing records when treating Cpl. Desmond in Nova Scotia. And these two private healthcare providers were Cathrine Chambers and Helen Boone.

SUBMISSIONS BY MS. MILLER

We heard there were outstanding consent form issues flowing within the VAC system. Ms. Chambers, of course, was a psychotherapist hired by Cpl. Desmond's VAC case manager. Helen Boone was a clinical care manager also hired by VAC as part of his care team. Both were retained by Veterans Affairs with the full endorsement of Cpl. Desmond. They formed a circle of care which should've had easy access to relevant information, including the discharge summary.

While VAC had many relevant medical records pertaining to the retainer of both these clinicians, including the discharge report, this information was not provided to Ms. Chambers, leaving her to start from scratch with Cpl. Desmond when he started for his initial assessment on December 2nd. Ms. Chambers understood that before she could access any of his medical records, she was required to get him to provide written consent allowing VAC to provide her with this material. This was despite VAC retaining her for the purposes of assessing Cpl. Desmond. She was never provided with the required consent forms from VAC, nor any additional material. Ms. Chambers was also responsible for seeking consent from Cpl. Desmond to allow her to communicate with his clinical care manager. We've heard no evidence in this situation that Cpl. Desmond had any objection

to the sharing of information through the VAC system, and certainly between these care providers. It is astounding that this was the process required for Ms. Chambers to obtain relevant background information about Cpl. Desmond and to be able to communicate with another member of his VAC care team. Ms. Chambers described the requirement to get consent to communicate with others on Cpl. Desmond's care team, all with the common goal of supporting him with this illness, as a barrier to his care.

I'm going to move now, Your Honour, to touch on examples illustrating failures to consider meaningful information. And there's two in particular I want to highlight. The first is a failure to consider meaningful information when it came to culturally-responsive mental health care provided to Cpl. Desmond and the second relates to issues with firearms.

Starting with culturally-responsive care, we heard the evidence of authors on behalf of the Health Association of African Canadians, and their report highlighted the challenges African Nova Scotians, especially males, have in accessing mental health care given systemic structural racism in the health care system. They were clear that for Cpl. Desmond to have been properly treated for his mental health issues, there

needed to have been culturally-responsive care provided with clinicians trained in cultural competency. It is not clear from the evidence if Cpl. Desmond received this care. Co-author, Robert Wright, noted the DSM-V provides that mental health clinicians are to undertake always a cultural formulation inventory, or "CFI", with each client. A CFI, by design, includes questions about patients' backgrounds in terms of their culture, race, ethnicity, religion, or geographic origin.

The evidence from this panel of witnesses, Your Honour, of course, happened late in the Inquiry, with many of the medical experts having given evidence prior to that. So health providers who treated Cpl. Desmond were not specifically asked whether they completed a cultural formulation inventory and, in fairness, not all witnesses were asked - although some were - if they had specifically considered race in any aspect of the care provided him. But, for those who were, it was apparent from their answers that they had not. Certainly, none of the treatment providers Cpl. Desmond saw were black.

Co-author, Cynthia Jordan, an experienced mental health nurse of almost 15 years, was employed by the Canadian Armed Forces for seven years from 2014 to 2021. While she had a wealth of cultural competency training in mental health, her

evidence was that there was no requirement for her to have such training for the CAF position, nor did the Armed Forces offer this training for its clinicians during the seven-year period she was employed. It is reasonable to assume Cpl. Desmond received no culturally-responsive mental health care from September 2011, when he was diagnosed with PTSD, to his release in 2015.

Mr. Wright was unequivocal in his evidence that given the ubiquity of the experience of black men, mental health clinicians could not properly treat a black man unless they understood the cultural experience of that man by gathering this information. The apparent failure to collect and consider this information, and the absence of what we believe to be culturally-responsive care clinicians in treating Cpl. Desmond, leads to a conclusion that on this issue, he did not have appropriate mental health care.

I'll move now, Your Honour, to firearms of interest to the police. This is a further example of a failure to consider relevant information. Firearms of interest to police - or FIPS, as they are called - were key pieces of the chronology involving Cpl. Desmond in November of 2015. We heard that there are only a few things that trigger the Provincial Firearms Office's

reinvolvement after an initial determination that someone is eligible to have a firearm possession license. These included somebody calling the public safety line; a call from a police officer advising that they were looking into a client file; and, thirdly, a FIP. The purpose of a FIP is to flag those individuals who may be no longer eligible to hold a license as a result of certain behaviour. FIPs are typically generated in two ways: Certain police occurrences automatically generate a FIP, i.e. a mental health issue, but the police can also manually enter a FIP if one is not auto-generated. The ability of the Provincial Firearms Office to do investigations and make informed decisions around client eligibility to hold a firearms license arising from a FIP relies largely on the correct coding and scoring of occurrences at the police level, which may then generate a FIP.

We heard evidence from one of the responding officers to a Nova Scotia firearms complaint in November of 2015 that he had no understanding of the interplay between the FIP coding and the resulting triggering of action by the Provincial Firearms Office.

The takeaway, Your Honour, from this is that more robust frontline officer education on the importance of FIP coding is

needed. The deficits in the FIP process were borne out in Cpl. Desmond's case as there were significant issues with the FIP system. In total, there ought to have been three, possibly four, FIPs generated based on Cpl. Desmond's interactions with the police in November 2015. However, ultimately, only one was recorded and investigated by the firearms officer who assessed his eligibility for having a license as a result of that FIP.

The second and third events were never auto-coded as FIPs, although it appears they should have been, and a fourth event was not available for the area firearms officer investigating the initial FIP, although that had taken place earlier in time. There are more details of this sequence contained in our written submissions, Your Honour.

The relevance of all of this is that the absence of those FIPs relating to the two November 2015 incidents meant the investigating area firearms officer did not have a complete picture of the relevant FIPs and the mental health behaviour necessary for screening his license eligibility. This, coupled with a complete absence of any of the contemporaneous medical records from the New Brunswick OSI Clinic psychologists and psychiatrists highlighting Cpl. Desmond's ongoing struggles and need for admission to Ste. Anne's as of December 2015, set the

stage for what was to come next.

(11:30)

I'm moving now to examples of failures to action. The most significant example of a failure to action, Your Honour, of course lies from our perspective with Veterans Affairs' failure to appoint a case manager for almost six months after the need for a case manager was determined following Cpl. Desmond's risk assessment and transition interview.

Veterans Affairs Client Service Delivery Notes, Exhibit 273, chronicle this timeline and demonstrate during this intervening period Cpl. Desmond did everything asked of him, including completing a rehab package on June 25th, which was not approved until over five months later on November 6th. He also continued to follow up regularly with Veterans Affairs no less than four times to inquire as to the status of the case manager he understood in May of 2015 would be assigned to him.

A further failure to action relevant care was in relation to the actioning of the clinical care manager. The evidence of Dr. Njoku, a psychiatrist with OSI New Brunswick, indicated the need for a clinical care manager was identified by him on August 31st, 2015, a full year before Ste. Anne's identified the need. Dr. Njoku's notes and his evidence confirm he identified the

need for a clinical case manager multiple times, on August 31st, 2015; December 3rd, 2015; and May 9th, 2016.

He assumed a referral for a clinical care manager had been sent to the VAC case manager shortly after he identified the need for one in August of 2015. There's no evidence the referral was made and, in any event, there was, of course, no case manager to send a referral to until at least three months later.

The failure to action, critical supports and investigations for Cpl. Desmond, of course, continued after discharge from Ste. Anne's. We know that the clinical care manager was identified as necessary by Ste. Anne's along with a neuropsychological report. And Cpl. Desmond was aware of both of these things. We know that because he communicated on August 24 to his psychologist in New Brunswick, Dr. Murgatroyd, that he was assigned a clinical care manager in Nova Scotia and he understood he would have further testing to assess a possible brain injury, of course the neuropsychological test.

Your Honour, one can only assume the ripple effects of these collective failures of action for a man who continued to follow up with his case manager, inquiring about the clinical care manager and other treatment recommendations from Ste.

Anne's that this would, no doubt, have added further to his system harm and mistrust.

And I want to talk now about that concept of system harm, specifically under the umbrella of appropriate mental health treatment. We know from the evidence that system harm is not a clinical term. I would suggest for Your Honour's consideration that it's a very relevant and compelling outcome to keep in mind when assessing the treatment that Cpl. Desmond received through the final months.

Nancy MacDonald, a registered therapist with over 24 years of experience and the Executive Director of Family Services of Eastern Nova Scotia, described the outcome of severe system harm on an individual as profound, with the result that it begins to become embedded in the individual that they are not heard, that they are not cared for, that they are not represented in society. The individual is left feeling that it's all inside them, which is not the case.

"Most of our high-risk individuals have immense experience with system harm, immense." It's a quote from Ms. MacDonald's September 15th evidence. One can imagine the sense of not being heard Cpl. Desmond would have felt given his experience with the multiple systems he interacted with after leaving the Canadian

Armed Forces.

Cpl. Desmond's system harm was, no doubt, compounded by the lengthy wait times to secure a Veterans Affairs case manager and then clinical care manager, and the number of times he had to retell his experience over and over to provide context to clinicians in the absence of meaningful and detailed medical histories.

In the just under three-month period from October 13th, 2016 to January 3rd, Cpl. Desmond had ten separate interactions with healthcare systems and providers for the first time where he would have had to explain his history largely because there was no prior history. This started on October 13th, 2016 at the Guysborough clinic with Dr. Harnish.

There was of course then in October 24th, 2016 an emergency room visit at St. Martha's. There was a November 2nd, 2016 visit to the Guysborough ER and clinic with Dr. Mahendrarajah. There was his November 30th, 2016 meeting with Helen Boone, his clinical care manager; a December 1st, 2016 visit to St. Martha's ER, where he left after three or four hours not having been seen because of a family issue; December 2nd, 2016, his consult with Dr. Slayter, two assessment visits with Cathrine Chambers on December 2nd and 15; a December 20th visit at the

Guysborough clinic with Dr. Khakpour, and then, of course, January 1st at St. Martha's ER.

Dr. Theriault addressed the impact of Cpl. Desmond having to repeatedly share his history in the absence of records by stating ... I'm going to quote from his evidence from November 2nd, 2021.

> At a minimum, it can be extremely frustrating. As I was mentioning, we've gone through a strategic review of our mental health and addictions programs, and one of the things that came forward in our review of that is how frustrating patients find it when they have to give their story several times over before they can get into a treatment program, because it can be seen by the patient as belittling or humiliating to sort of have to tell the same story over and over again.
>
> For someone like Mr. Desmond, who I think had general issues with trust in the sense of who he could trust and who he shouldn't trust, having to tell the same story over

and over again would potentially exacerbate those kinds of features. Because I've had lots of experience lots of times when I've tried to elicit a story from somebody, they would say, Well, didn't you read the record? Don't you already know that sort of thing? So it can undermine the person's trust in care provider at a time when it's critical, really, to try to make that rapport relationship.

Dr. Theriault also acknowledged that patients with a long history of mental health contact could fairly assume the person they were currently seeing would have some of that information and, as a consequence, fail to disclose all relevant information based on that assumption.

The end result, Your Honour, is a treatment provider with no records who has to start from scratch to obtain a history relying on a patient who assumes some of this information is or should be available. The patient has an ongoing erosion of trust with the clinician and experiences further system harm. This is not an optimal cycle for success.

I'm moving now, Your Honour, to address failures to

identify and address signs of domestic violence. Dr. Jaffe's expert report thoroughly addresses this issue, of course, with a conclusion that Cpl. Desmond had two equally pressing issues, mental health and intimate partner violence. However, from his perspective, the clinicians who saw Cpl. Desmond were not only effectively working in silos but they were only treating his mental health. He referenced them being in complete darkness when it came to considering, identifying, and addressing clear signs of domestic violence.

While domestic violence between Cpl. Desmond and Shanna was not addressed adequately, Dr. Jaffe concluded the danger to Aaliyah was completely overlooked with safety and protection of Aaliyah left to her grandmother. While there were multiple disclosures throughout Cpl. Desmond's medical records of behaviour that should have raised significant concerns about a potential suicide and/or homicide, awareness of the domestic violence risk factors appeared limited to physical violence behaviour. Dr. Jaffe's evidence and research with the Ontario Domestic Violence Death Review Committee noted the breadth of domestic violence risk factors well beyond physical violence.

Your Honour, our written submissions highlight in further detail specific examples of at least two occasions where

psychiatrists in Quebec and Nova Scotia identified the possibility of domestic violence but discounted it completely after satisfying themselves there had been no physical violence between Cpl. Desmond and his wife.

Further examples in our written submissions relate to a missed opportunity to record collateral information directly from Shanna Desmond in Nova Scotia which would have preserved detail around Aaliyah's exposure in the home to concerning behaviour in October of 2016. And there's also a missed opportunity from the Firearms Office to have obtained collateral information directly from Shanna in New Brunswick in 2016.

(11:40)

Again, these examples, Your Honour, are all provided by way of context for grounding recommendations we ask that Your Honour consider moving forward. These examples all demonstrate a focus on physical violence which reinforces that further education and training on the breadth and depth of what intimate partner violence encompasses is required.

I'm moving now, Your Honour, to the question of whether or not the deaths of Cpl. Desmond, Brenda, Aaliyah, and Shanna Desmond were preventable. Consistent throughout the medical records was that Cpl. Desmond continued to seek help in the

months leading up to the tragedy in addition to trying to access his own medical records.

In the face of a complex mental health illness, it is admirable how valiantly he fought to seek and receive care, repeatedly referencing his desire to become a better father and partner, suggesting he was very aware of the impact his mental health was having on his family. However, as his mental health and wellness continued to erode, there was a corresponding impact on his family's health and safety. This correlation is consistent with Robert Wright's evidence that, "Intimate partner violence is simply an expression of problematic mental health issues. So violence is supported by a lack of wellness or illness."

Evidence from family members and those who knew the couple before Cpl. Desmond's deployment to Afghanistan is also consistent with a marked change in his behaviour and presentation after his return home and subsequent onset of mental health issues. The conclusion of family and friends ... and we heard Mr. Coward share this as well in his presentation this morning, has consistently been that had Cpl. Desmond's mental health issues been supported appropriately, the subsequent deaths could have been prevented. We submit this

conclusion is supported by the Inquiry expert evidence which addressed whether the deaths of Cpl. Desmond, Shanna, Brenda, and Aaliyah were preventable.

Dr. Jaffe's research and evidence identified that one in eight homicides are domestic homicides. But of all homicides, domestic homicides are the most predictable and preventable. And that is, in large part, due to the years of research and work coming out of the Ontario Domestic Violence Death Review Committee and its finding of clearly identifiable risk factors for domestic homicide, of which he shared with us are currently 41. And the committee's view that if seven or more of those risk factors are present, then the risk for domestic homicide is high. In Cpl. Desmond's case, there were 20 risk factors.

Dr. Jaffe's opinion that the homicide/suicides were predictable and preventable had there not been a singular treatment focus on mental health. While the ending was predictable and preventable, it was not inevitable. He referred to the need for proper interventions at the earlier stages and the absence of this was a missed opportunity to create a different ending. And this was particularly the case, Your Honour, because the evidence was clear, that Cpl. Desmond wanted help.

SUBMISSIONS BY MS. MILLER

Dr. Theriault's evidence supports and identifies the proper interventions that were missing. He identified Cpl. Desmond's three main needs when he left St. Anne's as; one, ongoing PTSD treatment; two, exploration of issues with his wife and the level of paranoia with her, which would also include his feelings of general mistrust which were observed at Ste. Anne's with staff and his treatment team, not restricted to Shanna but in general, and; three, social aspects which included where he was going to live and how he was going to make ends meet. None of these three needs were addressed in any, let alone, meaningful ways upon his discharge.

Dr. Theriault identified that risk assessment could have been better done with more attention paid to Cpl. Desmond's hyperarousal symptoms, the broader instability of his social supports, and helping him come to some sort of resolution with respect to his marital issues. With respect to whether the tragedy was preventable, Dr. Theriault was clear that Cpl. Desmond's risk "could have been mitigated if he had a more consistent continuity of service provision over time".

I leave this, Your Honour, now to move into the recommendations on behalf of my client. As I said earlier, it was no one person or thing that led to this tragedy. And I

reference a Maya Angelou quote, "Do the best you can until you know better. Then when you know better, do better."

We now know better. The Inquiry is empowered with information to form recommendations falling within the February 14th, 2018 Inquiry terms of reference to build a system that does a much better job of supporting individuals and their families who struggle with mental health and intimate partner violence issues.

Our brief sets out over 30 recommendations. I don't profess to go through all of them this morning with you, Your Honour. They're there for your review. But I do want to highlight some of them and some of the background information relevant to them. The first area for recommendations that we've suggested relates, of course, to access to information and records.

The evidence highlighted a key issue and focus for recommendations in our submissions and that is how to meaningfully address the issue of information sharing in a way which balances administrative load, privacy, and ensuring optimal results for patient care and outcome. The sharing, collection, and actioning of information is a key component for future improvement.

In 2017, the Nova Scotia Auditor General's annual report noted one in five Canadians experienced mental health issues each year. Moving forward to 2022, the Nova Scotia website of the Canadian Mental Health Association notes that now one in three Canadians experience mental health issues or illness each year. When the impact on family and caregivers is considered, almost everyone in Canada is impacted by mental health issues and illness.

With the need for mental health services growing in Nova Scotia by the day, this Inquiry is well positioned to make impactful, positive change for the future with respect to mental health care and record management. Managing records in an efficient manner is going to be foundational to reducing system harm, optimizing care, and setting patients and their clinicians up for success.

Pragmatic solutions must consider the value of multiple consent forms which inherently lead to additional administration. The over-reliance on consent forms before record release can, in certain situations, act as a barrier to care. Sharing of medical information within medical systems should not always require consent if done within the circle of care concept that I talked about earlier and referenced in my

friend, the Health Authority's brief.

The success of these considerations will largely turn on the modernization of how healthcare records are stored and accessed and the effective and timely implementation of the One Patient-One Experience electronic health record system. But we know from the evidence we heard that system will not come for many years.

One of our recommendations, of which we have nine ... in this session, I'm just going to highlight a few of them though. One of our suggested recommendations is that the Province should enhance existing healthcare spending to prioritize and expedite the development of the One Patient-One Experience record system.

And the second recommendation for suggestion, we heard my friend, Mr. Rogers, talk about it yesterday, is recognizing that the development of the One Patient-One Experience system is going to take some time. We need to find a solution now. The suggested recommendation is the Province should fund and the Nova Scotia Health Authority should operationalize a record access solution office with staff designated to assist any Nova Scotian, medical or lay, in accessing medical records from agencies and/or healthcare providers outside Nova Scotia. We've included some detail around the suggested operationalization of

that office, Your Honour.

This is a concept, I think, that dovetails to some extent with Commission counsel's suggestion for a navigator. Certainly, we know that on October the 13th, Dr. Harnish could have utilized the access to such an office or navigator when Cpl. Desmond showed up at his office looking for the Ste. Anne's discharge. And we recall Dr. Harnish had to go on the computer to Google how to get ahold of Ste. Anne's and he gave that information to Cpl. Desmond. It also would have been of value with Dr. Slayter when he saw Cpl. Desmond later that month.

(11:50)

I recognize the practical constraints that my friend identified yesterday when he was addressing this recommendation but I do encourage Your Honour to consider a way that we could perhaps blend a combination of what we're suggesting and what Commission counsel is suggesting to address the more seamless and timely access to medical records that exist outside of the province, certainly for members like Lionel Desmond who may have records but any Nova Scotian who may have medical records before moving here.

Moving now to recommendations under what we've entitled Collection and Preservation of Collateral Family Information.

As I've said, there were missed opportunities for Nova Scotia healthcare providers to obtain more detail and robust information that addressed the mental health and domestic violence indicators highlighted in Dr. Jaffe's report. This information would have included collateral information from family members which, in turn, would have ensured more focused attention was paid to Aaliyah.

The collection of collateral information from family members, Your Honour, also serves a dual purpose of identifying family members who need their own support and resources to help manage a family member's mental health struggles. Many witnesses gave evidence in support of this recommendation. A requirement to capture collateral family information ensures it's preserved and accessible for consideration by future treatment providers, particularly in situations where the patient at a future point in time may not give permission for the mental health clinician to contact a spouse, such as was the case with Dr. Rahman on January 1st.

Our suggestion is that this information should also record if a contemporaneous ask was made by the physician or mental health staff to speak with the significant other or spouse that the request was declined. Dr. Rahman's evidence was that he'd

asked to call Shanna but Cpl. Desmond would not permit this. This detail was not charted in the ER record. We're not suggesting in any way that by not recording this detail, Dr. Rahman did something wrong. But what we are suggesting is that, moving forward, such detail should be recorded for treatment providers down the line to see and consider as relevant.

Including collateral family information, Your Honour, from our perspective is a way to ensure that professionals have robust and meaningful information to exercise their clinical judgement. We appreciate that the exercise of clinical judgement is something that needs to be left to the mental health provider, but what we want to make sure is that the information they are relying on is as robust as possible to allow them to make the best clinical judgement as a result.

Our recommendations around this topic include, as my friend reviewed yesterday, but that intake and discharge records should include a mandatory section which requires the consideration in summary of collateral information from family members. And I take my friend's point that they can't force people to give them this information, but I think having these sections in an intake and/or a discharge record at least makes mental health clinicians turn their mind to this in a meaningful way and

record the information if it is offered.

Moving now to culturally responsive mental health treatment. We endorse the recommendations outlined in the Health Association of African Canadians Report at pages nine and ten. It's Exhibit 347. In addition, we have the following recommendations. That the Department of Health, the Health Authority, and the Office of Mental Health and Addictions should reinstate the African Nova Scotia Mental Health and Addiction Initiative which ceased in 2016. Reinstatement would include the continuation of three prior initiatives which included regular province-wide conferences and training for practitioners to consider the mental health, addiction, and intimate partner violence, and response needs of African Nova Scotians.

Secondly, the implementation by Department of Health of an online cultural competency training curriculum, which we heard has already been developed, for all mental health clinicians.

And, thirdly, the formalization and support by the Health Authority and Department of Health of the African Nova Scotia Mental Health and Addictions network of professionals in the Centre of Excellence.

I'll move now, Your Honour, to a recommendation with respect to composition of the province's Domestic Violence Death

Review Committee. The Nova Scotia Death Review Committee Regulations were effective as of October 26, 2021. Section 3(2) of those regulations set out the committee must have a minimum of five members, including the Chair. Section 14 addresses the requirement for that committee to make an annual report and must include a summary of the committee's recommendations for system improvements arising out of its review of individual domestic violence deaths during the year.

From our perspective, Your Honour, it's key that recommendations and the information gleaned from the Domestic Violence Death Review Committee work, inform training awareness and policy work moving forward. Being purposeful about the composition of that committee should also assist with those goals. So our suggestion is that the Department of Justice ensure composition of the Domestic Violence Death Review Committee include a senior officer from Nova Scotia Firearms Office, a senior member of the Nova Scotia Advisory Committee on the Status of Women, a senior official from the Department of Justice Public Safety Division, and a senior educator from the Dalhousie Medical School. The purpose of this, Your Honour, is to assist with the transfer of information and knowledge back to the respective areas to cascade into awareness and action.

We have suggestions, as well, Your Honour, under Training for Professionals and Risk Factors for Intimate Partner Violence. There are eight of them. I'm not going to review them all but there are two key ones. The first one being that the Health Authority, the Nova Scotia Operational Stress Injury Clinic, and the Department of Justice should review the existing research on domestic violence risk factors stemming from the Ontario Domestic Violence Death Review Committee and then incorporate that research and those 41 factors into applicable risk assessment forms, one of which should include a specific risk assessment tool for children.

We also are suggesting that the Province and the Department of Justice should reinstate the Justice Learning Centre. This was an initiative from 2002 between the Department of Justice and the Nova Scotia Community College which was intended to provide "responsible education programs and services for Justice personnel on topics including domestic violence". We believe the scope of that Justice Learning Centre could also be expanded to ensure collaboration across silos in professionals which would address a recommendation from Dr. Jaffe to ensure that front-line professionals in multiple systems, such as health, mental health, education, social services, and the justice

system are up to date with the current information about domestic violence.

Moving now to a heading of "Family Support". As I stated when I opened my comments this morning, the struggle of the Desmond and Borden families extended outside of Cpl. Desmond's personal struggle. They all knew that something was different and wrong with Cpl. Desmond, as their brother, as their son, as their son-in-law, and they struggled themselves to understand what was going on.

The evidence before the Inquiry has clearly shown that while they needed support, they did not receive it. The Inquiry heard how frustrated and powerless family members felt when Cpl. Desmond returned home as they were given little education about how to support him and get help. We did hear, and I acknowledge, that the Canadian Armed Forces and Veterans Affairs had family resources. But what became apparent is that awareness of and access to these resources did not occur with the Desmond and Borden families.

Uniformly, the family recalled receiving no support from the Canadian Armed Forces or Veterans Affairs to help with Cpl. Desmond's illness before the tragedy. Uniformly, they all felt helpless.

Dr. Jaffe noted that while there was a lot of focus on Cpl. Desmond's return to the home, there needed to be similar and additional supports for Shanna and Aaliyah and, of course, for Brenda to support and manage his return home. Collecting collateral family information, Your Honour, which I previously addressed, will go a long way to assist in identifying when family members, themselves, need support and resources.

Inquiry evidence from Stephanie MacInnis-Langley and Nancy MacDonald also addressed that for resources to be optimally successful in terms of intimate partner violence and mental health there should be an enhanced focus on early intervention with men, supporting their wellness before charges are laid and the justice system is involved.

Ms. MacInnis-Langley talked about men needing space to show up safely and in control for themselves. She told us about the Antigonish Men's Health Centre opened in 2008 and the recently launched Men's Help Phone Line in 2020 as an important foundation to support mental health wellness. The Antigonish Men's Health Centre is particularly helpful for those who have no family physician.

So under this heading, Your Honour, we have three recommendations; one, that mental health first-aid courses

should be facilitated for family members of those with an operational stress injury. We understand those courses currently exist, but this recommendation is intended to ensure direct contact between family members and access to a course is provided, a warm handoff. Any funding required for such a course should be covered by the OSI Nova Scotia or the Department of Health.

(12:00)

We are also suggesting a recommendation that the Department of Health, Public Health, and Mental Health and Addictions should expand the Men's Health Centre in Antigonish from one day a week and establish regional health centres built on the same model across the province, which includes a family doctor, mental health provider, and a navigator. These centres should operate under memorandums of understanding so that funding concerns are removed providing clinicians with certainty and ability to focus on delivering services.

I am moving now to recommendations with respect to firearms, Your Honour. We heard that if the severity and complexity of Cpl. Desmond's PTSD had been known would have been a highly relevant factor in assessing whether or not he should have a gun license. Lysa Rossignol, the Acting Chief Firearm

Officer from New Brunswick said had she known about the December 2015 referral to Ste. Anne's, it would have changed the outcome of his license being reinstated.

With approximately 40 percent of all license reviews nationally involving a mental health component, this is from John Parkin's March 22nd recent evidence, it is clear that enhanced screening of gun owner applicants for significant mental health concerns is required. This screening needs to balance public safety with not stigmatizing individuals because of their mental health. While privacy is a concern, it's submitted that if one wants to secure a weapon, then the expectation should be clear that full transparency on the breadth and depth of an applicant's mental health is unequivocally required. Additional resources will be required to ensure this level of screening is completed.

We have a series of recommendations, Your Honour. There's seven of them but they stem primarily from the premise that the provincial firearms office should be staffed with a full-time mental health clinician who is specifically trained in domestic violence risk factors and can work collaboratively with the chief firearm officer to complete or obtain medical opinion on whether applicants should have or retain a gun license.

The application process would include a mandatory phone interview with the applicant's partner for initial applications and any review applications. These, I think, are consistent with recommendations put forward by my friend, Mr. Macdonald. The mental health clinician would be responsible for mandatory contact with the identified doctor on the application form.

And, lastly, there should be clear guidelines developed to provide to physicians who are requested to complete medical assessments for the purposes of securing a gun license. We heard from a number of physicians that that was a problem for them.

I missed a key one. There should be a statutory obligation for the doctor noted on the form to provide notice to the firearms officer of any concerns that arise in relation to ongoing treatment relating to mental health and/or domestic violence.

Lastly, Your Honour, I move to a final suggested recommendation which we have heard others speak about and that is a provincial implementation committee. The Inquiry heard evidence of important work done in the past in response to mental health, African Nova Scotia health issues, and domestic violence, which have been abandoned due to a variety of factors,

which included the Justice Learning Centre, the African Nova Scotia Mental Health and Addiction initiative.

There is also a concern that exists that current funding and support for programs could end with respect to, for example, the Antigonish Men's Health Centre.

As such, we strongly support Dr. Jaffe's recommendation that a provincial implementation committee be struck to ensure recommendations Your Honour pens flowing from this Inquiry are then executed and are not lost with the passage of time or change in government.

I have spent some time in my written submissions, Your Honour, addressing your ability to perhaps identify areas of desirable change for federal entities. I won't repeat them here other than to specifically highlight one relevant to family support. Of course, the law, as we understand it, is that you do have the ability to identify desirable areas for change at the federal level provided the foundation for these suggestions has arisen naturally from the evidence, which we submit it has.

The one area I want to highlight here is family support. Keeping in mind that a Veterans Affairs case manager is not assigned to a member unless a certain threshold for assistance is identified. It's reasonable to expect that if a case manager

is required for member support and transition, then there will be an inevitable impact on family members as well, which should not be ignored. Family members play a valuable role in helping support their loved ones with reintegration but expecting the member or the family member to understand the breadth and depth of a complexity, which has necessitated a case manager, is manifestly unfair to family members.

Our two suggestions for desirable recommendations are that Veterans Affairs case managers directly ensure veterans' family members are contacted and provided with resources and information to support them and the returning member. This means that there would be a warm reach out for that information. The case manager would also be responsible for ensuring family members were aware of and provided with funding to attend mental health first-aid courses with a specific focus on their family member's mental health diagnosis. Family members should also be provided with a case manager's contact information and encouraged to reach out to the case manager with any questions or concerns they may have.

As I close, Your Honour, I want to note that it has been a journey that I've enjoyed being on with all of you in the courtroom. It's been an honour, as I echo my friend's comments,

it's been an honour to work with all in this room and the Court and the Inquiry. I have gratitude to each and every one of you, especially Court staff, Elise Levangie and Selena Acker, and Ian Barker, who kept us livestreaming through the whole thing as we transitioned both from Guysborough to this courthouse. To the Borden family, we know that there were two families deeply impacted by the events of January 3rd, 2017 and well before and we appreciate your participation and courage with evidence of both Thelma, Ricky, Sheldon and Shonda.

It has been a true privilege and honour for me to work with the Desmond family. Chantel, Cassandra, Diane, Katlin, the courage you have displayed in the face of tremendous loss is really impressive. Your commitment, Chantel, and Cassandra, and your advocacy to push for an Inquiry, this was directly linked to these sisters' desire that no individual or family member experienced what Cpl. Desmond and his family went through before and after the January 3rd tragedy. I go back to that Maya Angelou quote, "Do the best you can until you know better. Then when you know better, do better."

Chantel, Cassandra, Diane, and Katlin, the lessons learned from this Inquiry will never replace the loss of your loved ones. However, I know there is great comfort in knowing the

truth of what happened to your brother and that recommendations flowing from this Inquiry will ensure no other family has to suffer the same. We now know better and we will do better.

Thank you, Your Honour.

THE COURT: Thank you, Ms. Miller.

Mr. Rodgers? Mr. Rodgers, I was going to suggest that if the podium is appropriate and gives you enough space to work, that's fine. The desktop podium that Ms. Miller had next to her, if you would be more accommodated at your own work area.

MR. RODGERS: Thank you, Your Honour. I think this space here is sufficient.

THE COURT: All right, thank you.

SUBMISSIONS BY MR. RODGERS

(12:08)

MR. RODGERS: Thank you, Your Honour.

Your Honour, I make these remarks on behalf of Cassandra Desmond, sister to the late Cpl. Lionel Desmond and his personal representative in this Inquiry.

On January 3rd, 2017, Cpl. Lionel Desmond woke up alone perhaps as alone as he had ever felt in his life. He had slept the night away from his beloved wife and daughter at Greencorn residence. His Aunt Sandra and Uncle Kenny had each left for work and his cousin had gone to school by the time he woke up. His wife, Shanna, and daughter, Aaliyah, were a few kilometers away in the family home. At Shanna's request, Cpl. Desmond had not been home the previous two nights.

(12:10)

The Greencorn residence is located in Lincolnville, Guysborough County, Nova Scotia. Lincolnville is one of the oldest black communities in Canada having been settled by freed slaves and Loyalists in 1784. It is a small rural community in Guysborough County situated on difficult to farm elevated land about 15 minutes drive from the Village of Guysborough, where children from Lincolnville go to a school and about 30 minutes

east of the Town of Antigonish.

Lionel Desmond was born on November 21st, 1983. He was raised in a six-bedroom bungalow home, which was his grandparents' house. His mother, Brenda, was a single mother raising all five of her children on her own with the help of her mother and father. Sadly, both Wilfred and Ardella Desmond have passed away since the tragic events and before this Inquiry was able to conclude. Both were highly revered within their family and community and both held on to their love for their grandson to their deaths.

As a further tragic coda to this tragedy, just a year and six months after the events of January 3rd, 2017, Cpl. Desmond's grandparents' house burnt down. So the family home in which Cpl. Desmond and his sisters were raised no longer stands. Precious memories of childhood and the good times that would have been spent there together and everything amongst those walls were left in ashes. Cassandra Desmond said that the only thing that they had to hold onto was her mother's personal items and her brother's Oath of Allegiance. That Oath of Allegiance was a big thing for Cpl. Desmond. There were many military members in his family, mainly from previous generations. He was very proud of himself because from his generation of the family,

he was one of the first to start back this military tradition in the Desmond family.

Cassandra found the Oath of Allegiance where it had fallen down behind a freezer. She describes seeing that the glass was shattered and it had a little burnt-ness up over the top, but you could read everything on it. She was able to save that memory of her brother and it seems poignant to think that, like the Oath of Allegiance, the memory of Cpl. Desmond may have some shattered glass and a little burnt-ness but it's still a most precious and meaningful possession.

Many of those Canadian Forces members in the Lincolnville community and Cpl. Desmond's family did not see past the rank of private being held back by the colour of their skin. So when it came to Lionel joining the military and becoming a corporal, there was a great deal of pride in the family and throughout the community.

Cpl. Desmond was described as the comedian of the household from the time he could talk. He was always cracking a joke and there was never a dull moment with him around. He was funny but he was also loving and caring and genuine, too. Lionel Desmond was a community kid, such that if he was not at home, he was likely over at a neighbour's helping out or doing something for

one of the elders in the community.

His oldest sister, Diane, describes Lionel as a good kid saying that he didn't ask for much in life and that he was always the one that if there was a snowstorm, he was out shovelling, helping everybody. If there was firewood needed, he would be out cutting the wood. She says he was a really active kid and a good kid. She said that before joining the military, her brother was harmless.

As he became older, Lionel was described as a kid to the kids. He was someone who would not hesitate to literally get down on the floor with the kids and play. It seemed he could identify with their innocence and could sit there and joke and play with them. Lionel loved the kids and the kids loved Lionel.

Lionel was very fit and athletic. He took good care of himself when it came to exercise. Paul Long was a guidance counsellor at the school in Guysborough when Cpl. Desmond was attending there. He made one of the recommendations at the time for Cpl. Desmond to join the military. Mr. Long knew Lionel both as a student and as a track athlete. He testified that Cpl. Desmond was a very good athlete, a great runner, and a great team guy. He was always a lot of fun. Mr. Long said that

there was always some good-natured carrying on with him.

Cpl. Desmond was a good student through high school and Mr. Long had all the confidence that he would do well in whatever he chose to do. In his recommendation for Cpl. Desmond to go into the Armed Forces, Mr. Long stated that Cpl. Desmond was very liked by his peers and staff at school, that he had been on the school cross country team, and was an active participant in the school intramural program. He stated that Cpl. Desmond's greatest attributes were his positive personality and his sincere work ethic.

Cpl. Orlando Trotter was in the same company as Cpl. Desmond and was a good friend. He knew Cpl. Desmond before the 2007 combat mission, served together with him in Afghanistan, and remained good friends afterwards. Cpl. Trotter had joined the military prior to Cpl. Desmond and served as something of a mentor for Cpl. Desmond while he was in training. Cpl. Trotter says that as a trainee, Lionel Desmond was somebody that was involved and was quite capable of learning new things. He said that one thing that stood out with him right away was he was very funny and liked to joke around. This matched Cpl. Trotter's personality and so it was easy for them to develop a close relationship with each other.

In terms of strengths, Cpl. Trotter said that fitness kept Cpl. Desmond going and that he was a good morale booster. In addition to fitness, Cpl. Trotter said that Cpl. Desmond was very eager to learn the communication systems and generally to learn as much as he could. These two friends trained together and served together in Afghanistan in 2007.

In the Inquiry, we heard from New Brunswick doctor, Dr. Paul Smith, who has treated hundreds of veterans in his clinic, and I will speak more about him later. Dr. Smith mentioned that whenever he hears that someone was in Afghanistan in 2007, that he knows they are going to be in rough shape. Cpl. Trotter gave us a sense of what that experience may have been like. He said that the seven months they were there, the war was relentless. When they first landed, they replaced another company just after Operation Medusa, which had produced many casualties. They started off at a small village compound where there were about four different homes. They were there for about a month, at first just gathering information trying to understand what was happening in the area. After that point, the fire fights started coming and Cpl. Trotter testified that they endured six months of continuous fire fights. As he described them, our soldiers would go out from the compound about midnight, they

would patrol for about four hours. Because the vehicles could not take them to some locations, they often had to walk to where the intelligence was telling them they had to be. Once the sun started coming up and the enemy had said their prayers, which our soldiers could hear, then it was just bullets. Cpl. Trotter explained that it was constant fighting that would last until about 10 or 11 a.m. and only cease because it was too hot at that point and both sides backed away until the next morning's battles.

Cpl. Trotter added that it was to the point that if they were not going on these operations, then the enemy would be firing mortars into their camp. So there was no time when you could relax and the whole time they were always on edge. He said you could just be sitting there hanging out talking and the next thing you know, a mortar lands into the camp and now you have to get kitted up and go out.

For Cpl. Trotter going back and thinking about Cpl. Desmond's experience and his reaction to it, he recalls that there were times he was very quiet and he remembers trying to talk to him. At that point, the two of them were very good friends but Cpl. Desmond sometimes just would not talk. He would always say he needed some time and so Cpl. Trotter gave

him his time.

In the years that followed his time in the war, Cpl. Desmond would describe nightmares arising from the traumatic memories from this time in his life. Cpl. Trotter struggled with his experiences as well and, like Cpl. Desmond, he also sought treatment upon his return. He testified that war was very new for all of them and none of them had ever been in those situations before so everyone needed their own time to make sense of it and it was tough for Cpl. Desmond.

Cpl. Trotter noted that while none of the members of their company died in Afghanistan, that he has seen that eight people from that company have committed suicide since returning to Canada. Cpl. Trotter said that Afghanistan was a bad tour. He said it was like going to hell and that is why so many people are struggling right now.

The question of how you prepare a soldier for battle is one that seems to be under explored in Canada. Cpl. Trotter testified that nowhere in his training was he prepared for seeing what an IED does to a human body, for example. Whether it is possible to prepare someone for such an experience and what the best method might be is worth exploring. In other places, as we have heard about Israel and Iran, there is

essentially a whole population who needs to go in to serve in the military and at least part of the answer is they are screened. It is not clear from what we have heard how extensive that screening process might be for those joining the Canadian Armed Forces.

(12:20)

Dr. Abraham Rudnick was an insightful witness on the topic of PTSD identification and treatment among other things. He has been published extensively on a range of topics, including post-traumatic stress disorder. Dr. Rudnick taught at Western and McMaster and, in fact, designed a course at Tel Aviv University on the philosophy of medicine. In Israel, Dr. Rudnick tells us there is an initial screening and anyone who is flagged as possibly having mental health challenges is sent to further assessment. Those who are not flagged and are considered mentally and physically healthy enough to start to serve, are then separated based on health into combat and noncombat tracks.

So far as his family was aware, Cpl. Desmond loved doing what he did. He loved fighting for his country. After Afghanistan, however, Cassandra Desmond tells us it was like that pride in everything could be seen just slowly deteriorating away from him. He was still proud but there was not that old

enthusiasm when he expressed himself. She said it was almost like you knew something had happened.

Everyone in the family saw the difference in him, but to ask him what was going on with him, especially in front of people, it was very difficult because nobody wanted to make him feel out of place and knowing that the old Lionel was so open and forthcoming, they felt that if he wanted to say something, he would, but he mostly kept to himself.

Exacerbating the impact of his traumatic experiences were the three concussions Cpl. Desmond suffered while in the Armed Forces. Cpl. Desmond described his head injuries in a letter to Veterans Affairs in 2015. In the letter, he says he was out cold for 20 minutes after an LAV rollover in training in 2006. Then in Afghanistan in 2007, he was on night patrol when a 10-foot high mud wall gave out from under him and he fell awkwardly on his back and head. And then he suffered another injury while landing after jumping from a plane in training.

In addition to exacerbating the effects of his PTSD, these concussions also seemed to have limited his cognitive capacity. Several care providers have noted Cpl. Desmond's inability to manage more than one or two instructions at a time, which would be inconsistent with the evidence of Paul Long and others about

Cpl. Desmond's mental abilities prior to his military service.

Cpl. Desmond awoke on January 3rd, 2017 a much different person than he had been 10 years prior. He was now a person who had suffered multiple head traumas, had been diagnosed with post- traumatic stress disorder after physically surviving the war in Afghanistan. His cognitive ability, his functioning and his focus were all affected and his ability to be able to pay attention and do normal life tasks everyday was very much diminished.

We do not know any of Cpl. Desmond's exact movements prior to 9:48 a.m. on January 3rd, 2017. At that time, Cpl. Desmond made a phone call to his wife but the call appears not to have been answered. The next minute, he sent her a text message wondering whether Aaliyah had gone to school. Cpl. Desmond then called the school to find out whether his daughter was in attendance and, presumably, he was told that she was.

We have seen through the phone records that Cpl. Desmond could be quite persistent in text messaging, especially to Shanna. On this day, however, we do not see anything in the records after 9:49 a.m., which may mean that he went to visit her in person knowing she would likely be alone in the house and available to speak with him. It seems likely that, in fact,

this did take place as it was after this time that Cpl. Desmond identified to Cathrine Chambers that Shanna had firmly conveyed to him that she wanted a divorce.

That brings me to the topic of family reintegration and how it should be part of the treatment plan for any veteran with a family. Shanna was not provided with any help from the military in terms of reintegrating Cpl. Desmond back into the household and their family. He was coming back a very different person from the kind and innocent man who had left for his deployment. But like every other military spouse, Shanna Desmond was expected to navigate this difficult reintegration by herself.

One of the major gaps in the discharge and reintegration process for a combat veteran is to have their family prepared to welcome them. There seems to be some material and some expertise on the subject of reintegration but it appears little effort is made to translate this expertise into action. A structured concerted effort to prepare families for reintegration and to normalize the idea that such a reintegration is not expected to be a simple seamless process would help manage expectations for the process.

It would help prevent idealization of what may, in many cases in reality be a difficult process of welcoming back

someone who has served their country with honour but under very difficult and life-changing circumstances. It appears that the only structured avenue for involving the family in treatment at Ste. Anne's, for example, was an available weekend visit. This visit was not, in a sense, part of the formal part of the treatment taking place at the facility, it was rather an opportunity for the patient and their family to connect for a few days as something of a break from treatment.

Cpl. Desmond had attempted to get funding for Shanna and Aaliyah to visit him in Montreal while he was undergoing residential treatment. This was rejected by Veterans Affairs on their view that there was no clinical need identified that would justify the expense. We now understand that there was, indeed, almost certainly a clinical benefit and it would seem to be an appropriate recommendation from this Inquiry to advise Veterans Affairs to seek out more ways to include the family of a veteran in their treatment.

The next certain event during the day of January 3rd, 2017 was a phone call that Cpl. Desmond made to Sun Life Financial at 11:22 a.m. We know that Cpl. Desmond visited the TD Bank in Port Hawkesbury the previous day after apparently having tried unsuccessfully to set up an account on line, a simple task for

most people his age.

We do not have specific evidence of the content of the call to Sun Life Financial but it seems probable that Cpl. Desmond was trying to sort out how he might establish his own accounts and ensure that his pension payments would go to their proper location.

The next certain event from January 3rd, 2017 is a telephone call that Cpl. Desmond initiated to Antigonish Family Services at 12:47 p.m. This fulfilled a promise that he had made to his clinical care coordinator, Helen Leudee, the day prior when he spoke to her in what she described as a crisis situation and she was able to provide some guidance to him. This phone call to Family Services was not answered at the time but was returned later in the day. Such a phone call on the part of Cpl. Desmond displays a future-oriented mindset and is consistent with his behaviour of looking for help and being proactive in his own care.

Ms. Leudee indicated that Cpl. Desmond was one of the more complex cases that might be referred out for care management services, yet she was willing to take him on as a client and was well qualified to do so. Unfortunately, though Cpl. Desmond left Ste. Anne's in mid August, her first meeting with him was

not until over three months later on November 30th, 2016.

They met at the Big Stop in Auld's Cove and Ms. Leudee indicated that the two gained a good rapport over a three-hour meeting that day. She said that Cpl. Desmond was forthcoming, wanted to engage with somebody and was motivated for self-improvement.

Her sense from this initial meeting was that hers was not going to be a brief intervention but rather something more involved and long term because of Cpl. Desmond's complex needs. Through her discussions with Cpl. Desmond, Ms. Leudee concluded that he did not have, or perhaps utilize a support network of friends and people to socialize with when he returned to Nova Scotia. He told her that he felt like an outsider.

Ms. Leudee knew from her discussions with Cpl. Desmond that she should not give him more than one or two assignments at a time as that would be more than his cognitive capacity could bear.

During the first meeting, Ms. Leudee indicated that finances were discussed but that Cpl. Desmond seemed to think his long term financial outlook was secure because Shanna's income from nursing would look after them. But the short term, there would have to be some arrangements made to manage bills

and living expenses.

She also noted that family reintegration was the most pressing need for Cpl. Desmond and was primary in his hierarchy of needs. She stated that it was not difficult for her to figure this out.

The day before the tragedy, on January 2nd, 2017, while on holiday, Mr. Leudee took a phone call from Cpl. Desmond. She indicated that on the phone call he was distressed over the state of his relationship with Shanna but she still felt that he was future oriented.

When Ms. Leudee saw Cpl. Desmond for the first time, she was meeting someone who had already gone through years of treatment. From their meetings, but notably not from any records being provided to her, she was starting to gain an appreciation for what he had endured, both in terms of traumatic experience and also in terms of treatment.

I would like to go back and look at some aspects of that post deployment treatment.

(12:30)

Immediately after the tour in Afghanistan, Cpl. Desmond's company went to what the soldiers call Decompression Cypress for three days to try to relax after being amped up from fighting

and the whole experience of being on tour. It was a chance to lay on a beach, have some drinks, get some sleep, and start processing what they had been through before getting home to their families. Cpl. Trotter says this three-day decompression experience is not enough and that as soon as the company returned to Canada, they were all split up and sent off to new assignments which was very difficult for the soldiers who had just been through such a life-changing experience together.

Some effort or consideration should be given to keeping these groups together for a longer, structured decompression and processing experience. Cpl. Trotter says it can be difficult to speak about the events in Afghanistan to somebody else who has never experienced that before; even a trained counsellor.

Dr. Rudnick testified that in order to have the best chance at successful treatment, once an issue is identified, it has to be treated early on. Dr. Rudnick testified that some studies were done on soldiers from World War II who had what was then called "shell shock" and which we now call "PTSD", who were treated on the spot in realtime with no delay and they showed, even then, that they could return them to full functionality and therefore prevent the onset of shell shock. Dr. Rudnick said that early intervention is crucial to try to reduce conversion

from acute stress disorder to the development of a more persistent disorder like PTSD. So all those services have to be available either in the theatre or immediately after the completion of the tour.

Different soldiers will react differently to experiences of the same battles and the same combat missions. Some will return home and go about their lives without receiving any treatment of any kind. Some will require counselling on a temporary basis or find the help they need through social connections with close friends and family members. This is particularly true, perhaps, when that other person is also someone who has experienced the military or combat of some kind. Others yet require long-term counselling to address mental health challenges to which active combat have given rise. This can, in cases, take on the appearance of a semi-permanent state of affairs where counselling becomes part of the veteran's weekly or monthly schedule or routine.

In some cases, more intense and focussed attention seems to be required and, for those veterans, residential treatment facilities suited to their particular needs and conditions are available throughout the country, although it may be noted that there seems to be an absence of such facilities in Atlantic

Canada despite Atlantic Canadians having disproportionately high numbers of citizens who engage in active military service.

Among the veterans who are referred to residential treatment programs, there is even a subgroup, to which Cpl. Desmond belonged, where the needs are such that the initial stabilization phase at treatment facilities lasts longer than usual or longer than expected. It seems fair to characterize Cpl. Desmond as being one of the more complex cases when looking at the entire needs spectrum of soldiers returning from Afghanistan.

After his tour and while he was still in the Canadian Armed Forces, Cpl. Desmond saw a psychiatrist and a PhD psychologist who treated him and he was provided with therapy sessions with a psychologist. After he was released from the Canadian Armed Forces in June 2015, his care was transitioned to the Operational Stress Injury Clinic in Fredericton. In December 2015, Dr. Murgatroyd from OSI New Brunswick had written to the Veterans Affairs case manager on behalf of Cpl. Desmond recommending that he be sent to the Ste. Anne's Stabilization and Rehabilitation program.

In his letter, Dr. Murgatroyd strongly recommended the admission of Cpl. Desmond to Ste. Anne's Stabilization

Residential Unit. He indicated that Cpl. Desmond had been diagnosed with chronic PTSD, quite severe; major depressive disorder; comorbid alcohol use disorder; and chronic pain. Dr. Murgatroyd noted Cpl. Desmond was prescribed medical marijuana, but was aware and agreeable to the admission criteria of no medical marijuana usage.

Dr. Murgatroyd noted as well that Cpl. Desmond struggled with disabling symptoms of PTSD that directly affected his social and occupational function. The goals of admission were for a medication reassessment, improving Cpl. Desmond's coping skills, increasing his structure of daily activities, and psychosocial rehabilitation. Dr. Murgatroyd indicated that once Cpl. Desmond was stabilized, he would have outpatient follow-up with the OSI Clinic.

Dr. Murgatroyd wrote that Cpl. Desmond had significant problems functioning in daily living which impacted his social and occupational functioning. His social support network was noted to be limited. Dr. Murgatroyd echoed comments we have heard elsewhere that Cpl. Desmond was motivated to actively engage in a treatment process. It was felt that Cpl. Desmond would highly benefit from psychosocial interventions.

While he was at Ste. Anne's, there was a relatively large

treatment team of people who were engaged with Cpl. Desmond: psychologists, psychiatrists, nurses, social workers, physiotherapists, rehabilitation therapists, occupational therapists, psychoeducators, and mental health nurses.

Cpl. Desmond was at Ste. Anne's from May until August of 2016. When he was getting ready to leave, the team of treatment providers at Ste. Anne's were on a conference call with Cpl. Desmond's outside care team to share their observations and recommendations in preparation of his discharge. One of the persons that was on that call was Ms. Doucette, his Veterans Affairs case manager.

I will come back to speak about Cpl. Desmond's treatment at Ste. Anne's but, first, I would like to review a specific requirement for entry into the facility: the requirement that all patients abstain from the consumption of cannabis prior to starting the program.

Dr. Ouellette, at the Ste. Anne's facility, noted that the directive is in place so that the psychiatrist may be able to establish a baseline for each patient and evaluate the effects of the medications from that baseline rather than having to try to parse it out against other potential effects that may be generated by the cannabis. While one can appreciate this

requirement from a scientific method perspective, it also seems there was a lack of appreciation, or even curiosity, among the doctors for the potential benefits of medical cannabis for someone with Cpl. Desmond's conditions.

After he returned from Afghanistan, Cpl. Desmond's family knew to expect that he would be different, and possibly on edge, in social situations, with one notable exception: any time that Cassandra Desmond was in Cpl. Desmond's presence and knowing that he was using his medical marijuana, she noticed that he was more laid back and relaxed. He was talkative. He did not really touch on his military career or anything. It was like that was not even part of his mental state to discuss. To his sister, it was almost like he had better control of his thoughts and his mind. He was more focussed. You could certainly have a conversation where he was not just bouncing around. And she described how it just seemed to settle him more.

Cpl. Desmond's uncle and good friend, Kenny Greencorn, had the same view. He said Lionel was happy when he smoked marijuana. He was calm. He loved to joke and carry on. While Mr. Greencorn observed Cpl. Desmond to seem nervous times, he would tell him, Have a little puff. Then Cpl. Desmond would consume some marijuana and he was happy and more like the old

Lionel. Mr. Greencorn found there to be a change in Lionel when he came back from Ste. Anne's in Montreal and he was on the pills that they had prescribed him and that this was not a good state of being for Cpl. Desmond. It is noteworthy that Cpl. Desmond did not consume any cannabis on January 3rd, 2017. The autopsy did not detect any drugs or alcohol in his system.

That brings us to the next recommendation. Treatment of PTSD symptoms with medical cannabis, in particular, when coupled with the model of peer support being developed by Dr. Paul Smith, seems to yield encouraging results and should be studied in both respects. On the structural side, I should suggest that this could be a provincial responsibility through the OSI Clinic.

Dr. Smith has 40 years of experience as a medical doctor. He has a specialized practice in assessment and utilization of medical marijuana and has had this specialization from 2014 to the present time. Dr. Smith has said that 75 percent of his 1,500 to 2,000 patients are military, and, of those, 85 to 90 percent of them consume medical marijuana. This has led to a significant reduction in suicidal ideation and improvement in their quality of life. Dr. Smith has noted the effects of medical marijuana have been positive with respect to their

social impact, impact on drug and alcohol use, marital and relationship harmony, pain severity, and reduction in suicidal thoughts.

Dr. Smith notes that more study needs to be done outside of Canada but, also, that he was aware of a 2018 study from the British Columbia Centre for Substance Use regarding PTSD and cannabis use which found that those who consumed cannabis were 60 to 65 percent less likely to have a major depressive episode or thoughts of suicide compared to those treated with pharmaceuticals. Dr. Smith notes that his own research is consistent with those findings.

Dr. Smith explained that in all cases, it was important for a user of medical cannabis to find their appropriate strain mixture and consumption level and that mentors or coaches, those being fellow users and veterans, would be best placed along with Dr. Smith to assist with this discovery process. At his facility, Dr. Smith has eight coaches, all of whom have university degrees of some kind. The clinic facility that Dr. Smith operates is basically like a Legion, except instead of going in and drinking alcohol, the veterans can go in and consume their medical cannabis.

(12:40)

SUBMISSIONS BY MR. RODGERS

This seems to be an idea that could be scaled up through a cooperative effort between the Health Authority and Veterans Affairs, or else existing Legions might wish to adapt themselves to this new environment where younger veterans may be more inclined to become involved.

Dr. Smith testified that he will usually start a patient with a very low dose and work their way upwards as the patient can tolerate the increase. Dr. Smith does not prescribe THC alone. He always has some CBD as he notes that CBD helps counteract some of the side-effects of the THC. Dr. Smith tries to help patients over the course of a few weeks find the level that is appropriate for them from a therapeutic perspective. This level is meant to be short of impairment. Sometimes, the THC and CBD mix must be adjusted and sometimes the strain needs to be changed. Dr. Smith noted that therapeutic stability is something every patient must seek and can only find the stability after it has been reached.

Dr. Smith started treating Cpl. Desmond in July 2015. He found Cpl. Desmond to be forthcoming with information. He had an interesting sense of humour and an easy conversation flow. He said that Cpl. Desmond wore his heart on his sleeve and there was no sense that he was misrepresenting himself. There is a

note from Dr. Smith's records on October 1, 2015, that says Lionel Desmond was doing well with his medical marijuana. He was taking four strains during various parts of the day. He was drinking very little at the time - perhaps only one or two beer per week - and was off all of his medications.

Cpl. Desmond had shown up several times to Dr. Smith's events. It appeared to him that Cpl. Desmond had lots of friends and that he a cheerful, outgoing personality. The testimony from Dr. Smith described a version of Cpl. Desmond that presented as similar to his pre-military personality. The mixture of comradery and cannabis that produced such an effect should not be lightly discounted.

That brings us back to the Ste. Anne's residential treatment facility. While staff at Ste. Anne's demonstrated significant expertise, empathy, and diligence with respect to the care of Cpl. Desmond, it also appears fair to conclude that his time at the facility can be thought of as having mixed levels of success. Though he was able to gain some insight into how he might manage his symptoms through exercise, art, and calm, slow reasoning, he also made the decision to leave the program early and noted that, when doing so, he had significant trust issues with the staff there. Given the manner in which he

left the facility, it would no doubt have been surprising, or perhaps shocking, for the treatment providers at Ste. Anne's to have learned afterwards that Cpl. Desmond returned home and managed to successfully reintegrate with his immediate family. As it was, the risk of an unsuccessful transition was high.

In fact, given what was known about Cpl. Desmond's marital situation, particularly by Kama Hamilton and Julie Beauchesne following their phone call with Shanna on August 12, 2016, the staff at Ste. Anne's quite likely knew they were sending Cpl. Desmond back home where he would quite likely be living either in domestic turmoil, or else in complete isolation, separated from his wife who was his main support. The departure from Ste. Anne's was handled very poorly and this Inquiry should make a recommendation as to how that transition is coordinated with provincial and private healthcare providers.

On August 9th, 2016, noted at page 45, Dr. Murgatroyd and the care providers at Ste. Anne's held a telephone call so there could be a verbal review of the recommendations from the facility. The indication from Ste. Anne's was that Dr. Murgatroyd would have the written assessment that was to accompany the recommendations within days; but, in fact, the report was not actually received until nearly two months later

on October 7, 2016, according to the faxed version of it.

We do not need to imagine the potential effects of such a delay in conveying the supporting written documentation to these recommendations. The effects have manifested themselves exactly as one might predict or fear they would. The detailed recommendations were either not properly conveyed verbally, not properly understood verbally, not properly noted by the recipient, or were properly noted but not actioned by the recipient.

Dr. Gagnon, who was the psychologist, had recommended a neuropsychological evaluation and she recommended emotional regulation therapy and also scheduled physical activity, and we know none of that was done or arranged for Cpl. Desmond.

Julie Beauchesne is an occupational therapist who also recommended a neuropsychological evaluation and a functional assessment by an occupational therapist and, that, we know, was not done.

Kama Hamilton, the social worker, had recommended pet therapy, participation in leisure activities such as maybe a cycling club or a yoga class, and that was not arranged.

Ms. Riccardi, the art therapist and a very insightful witness, had recommended that Cpl. Desmond get involved in some

kind of art program in the community and that psychotherapeutic art-based treatment was strongly recommended. That was something that seemed very helpful to him when he was at Ste. Anne's, but that wasn't done.

Marie-Eve Royer, the psychoeducator, had recommended that he see an addictions counsellor, which was not arranged. And then, Ms. Furland (sp?), the osteotherapist, had recommended Nordic walking or training in a gym under the supervision of a trainer, and that was not done either.

Upon discharge from a residential facility, the transition to outside care providers needs dedicated coordination. A case conference should take place, should be documented in realtime, and be structured with built-in oversight so that not all responsibility and knowledge lies with the case manager. Someone else must know what needs to happen and have a reliable system to ensure follow-up.

A complicating factor in the treatment of Cpl. Desmond was that his form of PTSD did not seem to respond well to traditional treatment modalities. It would seem that he did not have the basic version of PTSD but, rather, PTSD with dissociation which is a recognized condition under the DSM-V and one which the United States Department of Veterans Affairs says

can be found in 15 to 30 percent of PTSD sufferers. Many of his treatment providers, including Dr. Joshi, Dr. Njoku, Dr. Ouellette, and Dr. Gagnon, along with several laywitnesses, confirm that Cpl. Desmond displayed symptoms of dissociation. Knowing that PTSD is such a prevalent diagnosis and that future missions may be of such a traumatic nature as to be the genesis of a PTSD diagnosis in future combatants, it is important to not only be able to understand and treat PTSD, but also demonstrate to the Canadian public that this is so.

The post-deployment screening that took place after the 2007 mission in Afghanistan suggested that Cpl. Desmond had a hard time with deployment and he was far from the only one. Cpl. Trotter noted the same.

Dr. Rogers spoke about exposure therapy, this being the leading treatment methodology for post-traumatic stress disorder sufferers. Dr. Rogers was finding this to be successful with Cpl. Desmond, though we can look back now with some confidence and say that any exposure therapy treatment was necessarily going to bring only temporary benefit to Cpl. Desmond because of the complexities associated with his condition. These complexities were the dissociative episodes that he was experiencing which had been identified by multiple mental health

professionals treating Cpl. Desmond and cognitive impairments caused by the multiple concussions he suffered.

There may have been a connection with Cpl. Desmond's traumatic brain injury and some of his behaviour with Dr. Rogers; specifically, the flat affect he demonstrated seems to be consistent with a brain injury and may explain some of his cognitive difficulties. Dr. Rogers did not think it would've changed anything about her treatment as she was assessing cognition in managing the speed of the treatment by which she was able to witness in terms of Cpl. Desmond's condition and cognition. The brain injury seems to have affected his ability to write out an account of his time in Afghanistan and led to Dr. Rogers' decision to have him do a voice recording instead.

There is much that we do not seem to know about concussions arising from military service and how it may exacerbate other conditions. It was not possible here, but when it is possible, CTE scans of the brains of soldiers who have committed suicide should be undertaken to determine the extent to which they have suffered concussion-type injuries. Otherwise, without the dissociative episodes, exposure therapy does seem to be the most effective treatment methodology for PTSD sufferers. There is also the eye-movement desensitization method that has been shown

to be effective, though perhaps best used in combination with exposure therapy.

(12:50)

Dr. Rudnick identified the need for additional research and academic education in the area of PTSD and some of the various manifestations of it, such as dissociation. He also noted that such research is not currently a primary deliverable of the OSI Clinic structure. Further research is important, Dr. Rudnick noted, as the statistics worldwide, especially from Veterans Affairs in the United States, suggests that roughly 50 percent of people with military PTSD responded well to all the available evidence-based interventions. In other words, half of the population served by those clinics and treatment methodologies still need more research and development so more solutions may be found to help them.

Dr. Rudnick agreed that exposure therapy, which is the most common successful treatment method for PTSD, can be counterproductive in some cases, such as that of Cpl. Desmond. One reason is that if the PTSD has resulted from moral injury, which is when the soldier has done something that is antithetical to their moral being. In such cases, exposure to the action may simply retraumatize the patient without the

benefit of healthy processing. Then there is PTSD with dissociative episodes or dissociative disorder which can be a problem because the exposure therapy that psychiatrists may typically use to treat so-called regular PTSD may bring back, and does exacerbate, the dissociative symptoms. So a question emerges as to how best to address that dilemma.

What is dissociation is a good question. The more modern and common forms of PTSD with dissociative disorder would be depersonalization, which is when someone doesn't feel the same as they usually do. They may even have an out-of-body experience. Then there is derealization where the environment feels and looks different and they cannot function well in that type of experience. Extreme forms of PTSD with dissociative disorder would be what Dr. Rudnick calls a "fugue state" which is when a person is found in another place and doesn't remember how they got there. And other extreme forms are dissociative identity disorder or what was once called "split personality".

Dr. Rudnick testified that when someone is identified as having PTSD with dissociation, the psychotherapist would work with the patient in grounding techniques, helping them remove themselves from that dissociative experience as soon as possible so that they can get back to functioning through the

psychotherapy session and hopefully beyond that. Dr. Rudnick testified that, unfortunately, with some clients, it does not work and they continue to be triggered with dissociation.

Another unfortunate element of the state of PTSD with dissociation research and treatment is that there are no specific medications for dissociation. Unlike depression and anxiety, and even nightmares, Dr. Rudnick testified that for actual dissociation, to this day, there is no evidence-based medication. This appears to accurately describe Cpl. Desmond's condition and dilemma and may provide some insight into why his treatment history was extended over a relatively long timeframe and was fraught with setbacks.

Dr. Rudnick testified that the OSI Clinic attempts to provide both care in order to try to achieve remission, but also to provide care to try to achieve relapse prevention so that relapse does not occur. He stated that there are situations where, even with the best care and the best coping, that the client relapse will occur. He testified that a patient can achieve long-term remission, but there is no guarantee there will not be a relapse. With dissociation, because it's so closely linked to triggering or traumatic experiences, Dr. Rudnick testified that it is possible that anything in the

environment can trigger dissociation, even if the client has been doing well for a long time.

An additional difficulty identified by Dr. Rudnick was that some of these queues, these triggers, may be invisible and unnoticeable to anyone else but for that client because of a particular life experience with those traumas. That may be the cue and then they either have a flashback or they go into dissociative amnesia or they have a panic attack. This is the kind of condition Cpl. Desmond was dealing with in his mind every day. It was not getting better and he was concerned enough about it to seek help again and again.

The testimony from Dr. Rudnick on that point may be connected back to what Dr. Wendy Rogers indicated about her treatment of Cpl. Desmond and his PTSD. In February 2013, Cpl. Desmond finished his time with Dr. Rogers and she noted at that time that he had been successfully treated, which we can take to mean that his PTSD symptoms were in remission at the time. Though a provisional success, it appears that stressful situations would have the effect of undermining Cpl. Desmond's progress.

Months later, in September of 2013, there was just such a relapse. This appears to have been caused by an incident at

work where Cpl. Desmond was drinking milk and one of his fellow soldiers said something to the effect that he should be drinking chocolate milk, a remark which had clear racial connotations. It seems significant that a stressor that touched on Cpl. Desmond's racial identity would be the stressor that reanimated his PTSD to the point where Cpl. Desmond again sought treatment.

It may perhaps be the case that a stressor of another nature would have had the same effect but perhaps not. Here he was going through a rough time, and one of the people he most depends on, a fellow soldier, says something that cuts to the core, as such a racist comment can do. I will come back to dissociation as I describe some of the later events.

Next, I have some comments about Veterans Affairs but before I go there, and in touching on the racial issue with the chocolate milk incident, it is an appropriate time perhaps to discuss the issue of racial diversity among treatment providers. One of the issues that seems to have arisen for Cpl. Desmond while he was at Ste. Anne's was that care providers were often speaking in French around him. As he became mistrustful of their intentions, one of the ways this manifested itself was his suspicion that when they were speaking in French, they were talking about him in a derisive manner. This was detailed on a

note of August 10th, 2016. There was no hard evidence that this was actually the case, but it may still be evidence that cultural barriers played a role in the relative lack of success that Cpl. Desmond felt he experienced at Ste. Anne's. There were no other African Canadian or African Nova Scotian care providers or other participants in the program at the time Cpl. Desmond was attending. There were no attempts to connect Cpl. Desmond with African Canadian soldiers who could act as mentors or who could vouch for the facility from a cultural or racial perspective. This manifested itself in Cpl. Desmond being hesitant to accept the medications that were being provided to him at the facility.

And then back in Nova Scotia, you know, we've heard from the Health Association of African Canadians that in a very real way, Lionel Desmond could not receive proper health care in Nova Scotia simply by virtue of being a black man. We have heard from this highly-respected panel of witnesses representing the Health Association of African Canadians that systemic racism affects all aspects of service delivery in Nova Scotia; that the inability to access informed and culturally-specific health resources and culturally-competent care is a recurring reality; and that the least robust area of health care with respect to

culturally-specific approach is mental health. The recommendations in the Health Association of African Canadians report should be implemented including, most prominently, the proposed network of black mental health providers built from the work of the Nova Scotia Mental Health and Addictions strategy. This should be supported and adequately resourced. As well, Veterans Affairs and OSI should make their own efforts to ensure diversity among treatment providers.

Just a final point from the Health Association report. One thing that was discussed was how, as an African Canadian individual, before you consider taking that first step towards help, you do so with the knowledge that you are almost certainly going to experience racially-influenced microaggressions just by interacting with the health system in any way. That makes such an individual at least slightly less likely to seek help through the health system. And so these reasonably-anticipated microaggressions represent a systemic barrier to accessing health services for black Nova Scotians. Yet, despite all these barriers, some unique to his status as a soldier and some as a black man, Cpl. Desmond bravely sought help when he needed it time and time again. And that speaks to his strength of character and his determination.

This is a provincial Inquiry and we are all well aware of the jurisdictional issues that will impact the breadth of the recommendations that may emerge from this endeavour. Nevertheless, some comment on the actions and structure of our Federal Department of Veterans Affairs is essential in order to put the remainder of the recommendations in context. The collective listening to the witnesses from Veterans Affairs Canada brings to mind **The Castle** by Franz Kafka.

(13:00)

Nobody seems to have made a specific decision to purposively bring harm to Cpl. Lionel Desmond but the bureaucratic morass that has been established and sometimes altered with good intentions is so opaque and layered that an outsider or a user without great patience and cognitive capacity would have extreme difficulty navigating it to any productive effect.

In fact, this Inquiry has heard from a military clinician who had great difficulty navigating the system after suffering a concussion during her service, even though it was a system in which she herself worked. There appear to be no nefarious individual actors but rather a system which grinds and halts any creative or independent thinking in favour of adherence to the

system and it is the system as a whole which is destructive.

By way of comparison, we can make a general observation that everyone who saw Cpl. Desmond from outside the military seemed to have made either appropriate efforts or to have gone above and beyond in their efforts for him, disregarding procedural constraints when appropriate to do so. And included in this list would be Dr. Clark, Dr. Slayter, Dr. Rahman, the nurses at St. Martha's, Dr. Ali, Dr. Ranjini, Dr. Harnish, Cathrine Chambers, and Dr. Paul Smith.

Within Veterans Affairs, on the other hand, we have heard several examples of castle-like bureaucratic decision avoidance, which individually and collectively had drastic negative effects on Cpl. Desmond and no doubt others like him.

First, we heard from Marie-Paule Doucette that it took several layers of management to approve a simple prepayment for Cpl. Desmond's trip from New Brunswick to Montreal to attend Ste. Anne's, which was for medical treatment approved and coordinated within the VAC sphere. A Veterans Affairs case worker should be authorized to approve such requests rather than having this overly complex procedure for something that, in the end, costs the department no extra money.

This prepayment issue came up again when Cpl. Desmond was faced with the choice of whether to go to the OSI clinic in Halifax or rather see what services might be available locally for him in the fall of 2016.

When reviewing the situation from Cpl. Desmond's perspective, it is far from obvious that he really had a true choice. It's going to be difficult for Cpl. Desmond to get to the OSI clinic in Halifax in the first place without having a family doctor. But even if he did, Cpl. Desmond would have needed to pay for his own travel and other expenses and be reimbursed later, which was going to be difficult for him, logistically and financially.

The delay in having Helen Leudee begin her work as a clinical care manager is perhaps the most egregious example of the illogical inertia generated by heavily bureaucratic systems and organizational stagnation. One of the crucial requirements after Cpl. Desmond was discharged from Ste. Anne's residential facility in mid August was to coordinate the continuing care that he was in need of receiving. There was a stated urgency to several of the recommendations. In other words, counselling and other services were supposed to begin right away when Cpl. Desmond arrived home in Nova Scotia in mid August of 2016.

Ms. Leudee was not even contacted until about a month later and then was not able to start right away because Veterans Affairs had a rule that clinical care managers needed training on how to upload their notes into a government database. Unfortunately, there were delays and technical problems involved in the database training module delivery and so Ms. Leudee waited and Cpl. Desmond remained without a care coordinator, all without any compelling justification.

Ms. Leudee has testified that the training in the new system did not take more than a couple of hours and the system was quite simple to learn when she finally did take the training. The grim irony to this part of the story is that Ms. Leudee ended up taking the data entry training later in January 2017 after the tragic events.

On November 22nd, 2016, Helen Leudee was finally told by Marie-Paule Doucette to begin providing services, even though she did not have the training on the note uploading system. Ms. Leudee testified that she had no difficulty with proceeding in this manner. It did not change in any way her methodology of dealing with a client. She could still make her own handwritten notes and take action on items where action was required and simply upload her notes later into the system after she had

learned how to access it.

In other words, there was never a need for her to wait to get the training on the data entry system before providing services. The delay from August 16th until September 9th was due to Veterans Affairs not having contacted Ms. Leudee. The delay from September 9th until November 22nd was a result of unnecessary bureaucratic requirements that the clinical care worker be trained in the data entry system.

Ms. Leudee has never taken another client through Veterans Affairs. She testified that when she gets a client referral from other organizations, there is always a cover letter and some information provided in advance to assist her with planning for the particular individual. She testified that she receives this kind of information 99 percent of the time but not with Veterans Affairs. Her frustration with Veterans Affairs is the reason why she has decided not to take any further clients from them.

Next, we learned on the eve of testimony of a key federal witness, case manager Marie-Paule Doucette, that an internal review of this tragedy was, in fact, done by the military and Veterans Affairs, that the review had been in existence for years, and that they were refusing to let anyone see it. No

liability findings are being made in this Inquiry, yet the federal government would not release the report to the Inquiry or otherwise in a public forum without having first been ordered to do so.

An inherent weakness in a bureaucratic organization is that when something is not specifically in someone's job description that thing just does not get done. The immediate aftermath of the tragedy seems to demonstrate that Veterans Affairs needs a suicide/homicide plan.

Here, it was coincidental, good fortune, that family member Junior MacLellan, was a retired warrant officer and he was capable of arranging matters after the tragedy. In doing so, he showed a degree of courage that is commendable and worthy of note. Junior did much of the coordination of the funerals and arranging funeral services and the burials. He also figured out how it was going to be paid for and was able to use his skills developed as a warrant officer in order to do so. This was not easy for him to do because he had his own mental health struggles. But he felt the responsibility to Wilfred Desmond and to the Desmond family and so he got to work. The tremendous efforts made by Junior MacLellan in this situation calls into question why someone from Veterans Affairs was not immediately

on the scene doing this instead. If not for the very specific good fortune of having a formal warrant officer as basically part of the family, tragedy would have been layered with chaos.

Even well after this tragedy, evidence of the lethargic structure and communication gaps within Veterans Affairs were manifestly present. When dealing with Dr. Alexandra Heber, Chief of Psychiatry at Veterans Affairs, Cassandra Desmond was reminded of the Veterans Affairs Service Assistance line and was told that if she needed to talk to someone, all phone personnel had been made aware of the Desmond family tragedy and would be prepared to speak with her. Ms. Desmond never contacted the Services Assistance line until January 3rd of 2018, a one-year anniversary date of the tragedy that took her beloved mother, sister-in-law, niece, and brother.

Ms. Desmond's emotions were understandably high and like all over the place and stuff and everything as she described them at the time. Ms. Desmond phoned in thinking she would just have to give the information that she was told to give and that things would start flowing from there. But as we have heard, it did not work out like that. Ms. Desmond told the person on the line that she was calling in that day because it's the one-year university and she was ready to start the journey of healing.

Unfortunately, the worker had no idea what tragedy Ms. Desmond was talking about, the Desmond name, or any tragedy that occurred in Nova Scotia. Ms. Desmond's response is telling. She testified that she told the worker it was okay, she didn't even know why she bothered calling this line. She testified that her brother probably tried calling this line or something like it and now she's calling in and they are sitting there telling her that what a senior official had told her was a lie because nothing had been set up.

Now I'll bring us back to the events of January 3rd, 2017. After calling Family Services at approximately 1 p.m., Cpl. Desmond showed up in person at St. Martha's to book an appointment with Dr. Slayter for January 18th, 2017. This means he drove from Lincolnville to Antigonish sometime in the previous three hours but most likely between 12 noon and 1 p.m.

Soon after having rebooked his appointment with Dr. Slayter, Cpl. Desmond took a telephone call from his therapist, Cathrine Chambers, who he had tried to contact the day before. Ms. Chambers was and would have been an appropriate local counsellor for Cpl. Desmond. Ms. Chambers testified that Cpl. Desmond was a complex case and that she thought she would need six appointments, just to do the assessment, and she noted in

her testimony that this is the full amount or the longest she would ever expect to take with an individual in order to complete the initial assessment.

(13:10)

As it turned out, Ms. Chambers only had two 50-minute appointments with Cpl. Desmond along with one telephone call which took place on January 3rd, 2017. Before discussing that call, it is noteworthy that when asked about obtaining records from Veterans Affairs, Ms. Chambers stated that it would usually be offered by the case manager without her having to ask for the records. Here, with Cpl. Desmond, it was not offered by Ms. Doucette. Ms. Chambers had not yet requested the records. She gave the opinion that very little information had been provided by Veteran Affairs to her.

Regarding the phone call of January 3rd, 2017, Ms. Chambers testified that she had a voicemail from Cpl. Desmond asking for confirmation of his appointment time. She had called him on January 3rd only for the purpose of confirming the appointment time which was for two weeks later. When she got on the phone with him, however, she got the sense that he was in a crisis and so she continued with the phone call. He told her he had been in an automobile accident so it seemed possible to her that it

had reactivated his PTSD symptoms.

Ms. Chambers testified that Cpl. Desmond told her that Shanna had insisted that he go to the hospital on January 1st, 2017. Ms. Chambers asked Cpl. Desmond whether he had thoughts of self-harm or harming others and he answered that he had no plans in those regards. She said he spoke calmly and talked about housing and pensions and banking situations. He appeared oriented to the future. They discussed what it would take for him to go back to the hospital and agreed that if he had thoughts of blowing himself up, harming others that he would immediately take himself to the hospital. Ms. Chambers noted Cpl. Desmond was very nonlinear in his speech during this phone call and that it took 26 minutes to get two minutes' worth of information from him. She told him that they did not have to figure everything out today, that he would have lots of support in the future. And, on the phone call, Cpl. Desmond could not remember or did not say whether he had received medications or seen the psychiatrist.

Your Honour, we reviewed some documents including the Ste. Anne's discharge report with Ms. Chambers and asked for her reaction to what was known by other but not conveyed to her as Cpl. Desmond's therapist. After she reviewed this information,

she said that had she known this; i.e., what was in the discharge report, she would have recommended inpatient care for Cpl. Desmond. She says without cognitive wellness in Cpl. Desmond, her interventions would not be effective.

This really gets to the heart of the matter. Veterans Affairs had detailed reports that would have dramatically affected the plan of subsequent care providers yet these reports were not provided to the Health Authority or private care providers.

Those here certainly will recall that Ms. Chambers became quite emotional upon hearing that there was additional information which had not been provided to her and which would have been very helpful. There are other examples throughout the Inquiry testimony where witnesses were similarly overcome with emotion. For many, this was their first experience with such tragedy despite, in some cases, having been in the mental field for many years.

I think it is proper to commend you, Judge Zimmer, for reassuring those witnesses who may otherwise have felt some degree of responsibility and guilt, that they did nothing wrong or had performed appropriately given the limited information which had been provided to them. We never know what impact our

words might have but I suspect and hope that those reassurances were deeply felt.

Some of the key testimony from Ms. Chambers involved the issue of medical record sharing and we have heard that issue raised numerous times in testimony during this Inquiry. A serving member of the Canadian Armed Forces will eventually and almost invariably become a user or patient of a provincial health system. It is clear in all we have heard that the Health Authority should work with the Armed Forces and Veterans Affairs to develop a simplified protocol for the transfer of declassified health records from veterans upon their discharge. The militant dedication to respecting patient privacy may need some flexibility in this regard. Part of this will likely involve the veteran being assigned at least a caretaker or family doctor upon discharge. The search for a family doctor may be more complicated for some veterans who have complex cases and who thus may have difficulty finding a doctor to take them on. Having an automatic linkage such as this would ensure that no gaps would exist, such as were identified with respect to the OSI Halifax requiring Cpl. Desmond to have a family doctor prior to receiving treatment there.

If there is no connection made, it can have a big impact.

In Cpl. Desmond's case, he would have hopefully been taken in as a patient in the Guysborough Medical Clinic with either Dr. Ali or Dr. Ranjini, both of whom had experiences of war from their own countries before coming to Canada. Either or both would have been very appropriate family doctor options for Cpl. Desmond.

Records are important and it may not be sufficient for the discharge of a veteran to just be given a copy of their records upon leaving the military. Dr. Rahman and Dr. Slayter both treated Cpl. Desmond when he visited St. Martha's Regional Hospital of his own accord seeking help. They seemed to grasp the complexity of the situation and both made extra efforts to try to understand and help Lionel Desmond but they were coming in blind to a patient with highly unique experiences and an extensive treatment history within a system of health care delivery about which they knew almost nothing.

I asked both Dr. Rahman and Dr. Slayter about their awareness of the Veterans Affairs facilities, including the Ste. Anne's residential facility, the OSI clinics. Neither were particularly aware of them nor did they know the psychiatrists there. Nothing is provided to the psychiatrists in the provincial system when a veteran is moving to their area, even

veterans such as Cpl. Desmond with a long history of psychiatric involvement while he was in the military and leading up to his discharge. This needs to change.

Psychiatric emergency physicians need to know what might be coming their way, both in a broad sense of knowing what varieties of diagnoses are common and what treatments are seen to be effective but also in the specific sense of being able to access the emergency patient records. Surely there can be a protocol for what might be redacted for security purposes. Then at least Dr. Rahman or Dr. Slayer could have known what they were dealing with and someone in the position of Cpl. Desmond would not be forced again and again to tell their story of trauma.

Who knows how things may have developed differently but information is almost always going to be helpful. Criminal records cross provincial borders and jurisdictions, so why not health records? Jurisdictional impediments need to be overcome.

Cpl. Desmond's call with his therapist on January 3rd, 2017, lasted 25 minutes between 1:15 and 1:40 p.m. At the end of the telephone call with Ms. Chambers, Cpl. Desmond agreed to a safety plan whereby he committed to telephoning for help or going to the emergency room should he deteriorate such that he

has feelings of suicidality.

We have heard testimony that such safety plans are one of the leading recommendations as far as manners of preventing someone from falling through on any dark thoughts that may enter in moments of deep depression or crisis. Ms. Chambers was an example of a local private therapist who had training and experience treating military veterans. That may not be a commonly available skillset in other small towns or rural areas in Nova Scotia. It would seem helpful, therefore, that the provincially-operated OSI Halifax should systematically share their expertise with private providers with whom veterans will be working.

Dr. Rudnick with his teaching experience may be uniquely well positioned to providing training opportunities for private care providers throughout the province or region with respect to treatment of PTSD and other common conditions observed in discharged soldiers.

This would be one way of providing greater access to some of the specialized expertise which is held by those working at the OSI Clinic. This may be a good way or perhaps the best way of serving veterans in rural parts of Nova Scotia. The other way will be to continue the increased usage of video so as to

preclude the necessity of veterans traveling to Halifax to access OSI services.

Following the telephone call with Ms. Chambers, Cpl. Desmond heard back from Antigonish Family Services office. We have heard that Cpl. Desmond went from asking about couple's counselling in December to an inquiry about individual counselling on this telephone call of January 3rd, 2017. The phone call was relatively short, lasting from 1:54 to 2:01 p.m. This change in request from couple's to individual counselling may support the idea that Cpl. Desmond went to see his wife that morning and was told definitively that their relationship was over.

The intake form from the Antigonish Family Services office also shows that Cpl. Desmond had an appointment arranged with a counsellor in Sydney for January 16th, 2017, which of course is another forward thinking future-oriented action.

(13:20)

It would appear that after these telephone calls, sometime between 2 and 3 p.m., Cpl. Desmond drove back from Antigonish to the Greencorn house, though it may have been earlier while he was on the phone. If he was driving back from Antigonish while he was speaking with Ms. Chambers, he could have arrived back in

the Upper Big Tracadie/Lincolnville area as early as 1:40 p.m. but the next time we know his location with any certainty is at 3:05 p.m. when he was observed leaving the Greencorn house by his cousins, who were getting off the school bus at the time, and saw Cpl. Desmond as he was driving his car out the driveway. He left the home in his car, not the SUV, which he was later driving. He was well dressed in the clothing he was seen wearing at Leaves & Limbs, rather than the camouflage he was later discovered to have been wearing. When he saw his cousins getting off the bus, he waved and smiled. It seems noteworthy that Cpl. Desmond was not texting or calling anyone in his family or friends all day to tell them what he was doing or what he was thinking.

At approximately the same time at 3 p.m., so far as we are aware, unknown to Cpl. Desmond, Shanna was placing a phone call to the Naomi Society in Antigonish, an organization we have heard praised during this Inquiry. Executive Director Nicole Mann testified that Ms. Desmond was not in distress and nothing about the call triggered any concern for the intake worker. Shanna did not even provide her name at the time and did not express any fear for her own safety but was seeking information. This, again, seems to confirm that the divorce discussion was

fresh.

Shanna was strong, determined and capable as a wife, mother, and nurse. She had essentially been a single mother for 10-plus years with Brenda, Diane, Thelma, Shonda, and others in the extended families supporting her while she pursued her education and raised Aaliyah. As a new nurse with her career in front of her, she was well positioned to care for Cpl. Desmond and to help coordinate services on his behalf. She was also in a good position to support the family financially through her earnings. Shanna had very little contact with the military. She did not get any help from the military or Veterans Affairs during Cpl. Desmond's transition and she may have had very little idea of what to expect or how to cope.

This was a beautiful couple with a beautiful daughter who loved each other and wanted things to work out but who did not know how to talk to each other and did not understand the changes the other had been through. Both were clearly motivated to try. Shanna went with Lionel to appointments at times and was patient with him for years during his treatment. They had every hope of a long loving life together, her as a nurse and Lionel no doubt finding a fulfilling path in his own time.

Dr. Jaffe identified many factors that are present for

those leaving the military that put people at risk of domestic violence. The adjustment to a peaceful atmosphere can be difficult. There is familiarity in firearms and there are often mental health challenges at play.

Firearms access is an important issue that I will be coming to but the real question here is, what was it about seven months in the war zone or perhaps the Afghanistan war zone, in particular, that changed this fountain of positivity and many others like him into someone who was impatient, deeply depressed, paranoid, cognitively impaired, and who ultimately saw no other way out. This was violence in a domestic context but not a simple matter of domestic violence. The underlying causes must be recognized as must the limitations on the free will of someone with multiple concussions and complex dissociative PTSD. The real Lionel Desmond did not commit these acts.

Between 3:05 and 4 p.m., Cpl. Desmond was driving to Antigonish. The next time we know for certain his location is between 4 p.m. and 4:22 when he was inside Leaves & Limbs purchasing the rifle and some ammunition. The drive from Lincolnville to Lower South River where Leaves & Limbs is located would normally take approximately 30 minutes. So it is

possible that Cpl. Desmond did not take a direct route at this time.

There is something unusual and perhaps noteworthy. Between 1 p.m. when Cpl. Desmond left St. Martha's and 3:05 p.m. when he left the Greenhorn house, he must have driven from Antigonish back to Lincolnville only to then turn around and almost immediately go back to Antigonish to Leaves & Limbs. This raises the question as to when Cpl. Desmond decided to buy a firearm.

His internet search history would suggest that he was looking at firearms on line for a few days prior to the 3rd. If he had been planning to purchase for that specific day, even for a few hours since that morning, it would have made more sense to stop at Leaves & Limbs on the way home from Antigonish rather than driving home and turning around within a very short timeframe. It is possible, therefore, that he decided after he returned home from Antigonish to purchase the firearm.

Cpl. Desmond was calm and patient at Leaves & Limbs, as confirmed by Dr. Rahman, who watched the video. Cpl. Desmond saw his longtime friend, Trevor Pelley, at the store and exchanged some small talk. He waited his turn while the owner of the store was dealing with other customers with no sign of

agitation or impatience.

There are some unexplained behaviours in purchasing decisions made by Cpl. Desmond during this visit which I reviewed with Dr. Theriault. Outward it has the appearance of someone who planned to have the rifle for years to come. It seems unlikely that Cpl. Desmond was trying to deceive any onlookers as deception was not his style, he had no obvious reason to think he was being watched, and he may not have had the cognitive capacity to successfully pull off such an act if he had considered doing to.

Certainly, an important question in this Inquiry is how a person with a diagnosis, treatment history and mental health status that Cpl. Desmond had on January 3rd, 2017 could purchase a rifle and ammunition.

In this Inquiry, we have learned that there are three disconnects in the firearm licensing realm that help explain how. There is a disconnect between the military and civilian firearm systems such that, because of his known mental health conditions, Cpl. Desmond was denied firearms while serving in the military but not at home. Such information does not get transferred to the civilian authorities.

There is an interprovincial disconnect. Despite being a

national program, information was not always or automatically shared between neighbouring New Brunswick and Nova Scotia when police deemed a situation merited noted in the firearms database. This seems to be one, among several pieces of evidence, suggesting that more resources are needed at the front end of this firearms system doing proper analysis and data entry.

Another is that we also heard that it can take weeks for a license to be officially placed under review in the system, which can be a real problem because, of course, right after an incident that would precipitate such a review is likely the time when that information might be most needed. The firearms offices should have the resources available to be able to make decisions on police reports the day they are received. In addition, the police should be able to check the validity of a firearms license instantaneously and that information should include whether the license is under review.

Finally, there is a license disconnect. Sellers can, but are not required, to check the national license database before selling a gun. We heard in this Inquiry that when a person goes to a vendor to purchase a firearm, the vendor is supposed to call in or use the business web service to check on the validity

of a license but there is little enforcement or oversight and so there is certainly no guarantee that this takes place. The firearms office does some inspections of businesses but from the testimony it would appear that this is quite infrequent.

A simple recommendation may be to require businesses to check the database before selling a firearm. Viewing a card is not enough.

The third disconnect did not manifest itself in this case. As anyone checking the database would have seen that Cpl. Desmond had a valid license but the first two disconnects did. Cpl. Desmond was not permitted to use a firearm on duty but he could in civilian life. And there was important police information known in Nova Scotia that was not known to the New Brunswick firearms office that reinstated his license.

Leaves & Limbs is an outdoors store near Antigonish, which was where of Cpl. Desmond purchased the SKS rifle. The owner knew Cpl. Desmond from having seen him in the store before in late November/early December 2016 and he also knew Cpl. Desmond's grandfather, Wilfred Desmond.

There are some unexplained behaviours in purchasing decisions made by Cpl. Desmond during this visit. First of all, his calm demeanour and lack of agitation is in stark contrast to

how his therapist described him as presenting and being just two hours earlier. Then what he bought versus what he did do not match up.

If his intention was to go kill his wife, then all he needed was the most basic rifle and basic ammunition. The purchases he made seemed more in line with someone who is legitimately seeking a firearm for hunting. He bought good ammunition, a good rifle with a scope, spent his money wisely getting good value for a used firearm, rather than purchasing new one, but then opting for the much better ammunition at an extra cost of only $30.

Cpl. Desmond's internet search history certainly reveals that he searched for firearms. He also searched for furniture, gym memberships, tried to open a new bank account, looked for horse tack and supplies for his daughter, read relationship websites for dating your spouse, and he emailed Bogs about returning a pair of boots. These are all future-oriented activities and suggest that the purchase of a firearm was not as simple a purchase as it may first appeared to have been.

(13:30)

There were other future-oriented activities talking place around this time as well. Getting medical attention from Dr.

Ali for his cut finger, going to see Dr. Slayter, scheduling his next appointment with Dr. Slayter, telling his Uncle Kenny he would help him build a shed the next weekend and contacting the Antigonish Family Services are all things done with future in clear view.

Other than purchasing the gun, which has its own internal conflicts, as I've just said, there are absolutely no pieces of physical or electronic evidence that suggest this was coming. No notes, no texts, no letting responsibilities lapse, no other single thing we can point to, looking back, and say, Ahh, that's what that meant. It is all very difficult to reconcile.

After he left Leaves & Limbs at 4:22 p.m., we might presume that Cpl. Desmond drove back to Lincolnville arriving as early as 4:50. Between 4:50 and 6 p.m. sometime, he arrived, changed into his camouflage clothing and switched vehicles from his car to the Ford Escape. Cpl. Desmond would have known that both his Uncle Kenny and Aunt Sandra would be away working at this time. It is likely that Cpl. Desmond would have also known about the after-school program his sister Chantel was operating that evening and perhaps had been counting on the children attending it at that time.

What could he have been thinking during this time alone?

Cpl. Desmond switched vehicles to the Ford Escape, which would be better suited to the woods road where he was heading. In the Escape were found the appointment cards for his upcoming appointment with Dr. Slayter and Cpl. Desmond's military Go Bag, which we are told was packed at all times.

And the next time we know for certain is 6:05 p.m., which is the time the call went out from Brenda Desmond to her brother George. Sometime before 6:05 p.m., obviously Cpl. Desmond walked the approximately one kilometer down from the Escape through a path in the woods. He was carrying a knife, his rifle, and a box of ammunition.

He used his knife to slice the two tires on the driver's side of the new truck his wife had recently purchased. This truck was, superficially at least, the focal point of some dispute between the couple. The original purchase was a source of concern of Cpl. Desmond because of the expense of the vehicle, though Shanna needed reliable transportation to get back and forth to work. More recently, it was the truck that Cpl. Desmond had put in the ditch at the New Year's Eve party which appears to have tipped off the critical events.

The dispute over the truck going into the ditch which generated a reaction from Cpl. Desmond that those around him

could not properly comprehend seems to have been the fuel for a verbal argument between Cpl. Desmond and Shanna that then escalated to the point where she had had enough. It may be tempting to attribute the act of slicing the tires to animosity towards the truck itself. The effect, however, of the damage that was done was to make it immobile and prevent escape. If the motivation for the damage was animosity towards the truck itself, he may have scratched the paint or dented the hood rather than quietly flattening the two tires on one side.

Cpl. Desmond carried the box of bullets to the house with him. Given what ultimately took place, it is not clear why he would have carried the full box rather than just a magazine. It suggests he may not have had a clear picture of what was going to take place.

The television was on in the back room. It seems likely that Aaliyah and possibly Brenda and Aaliyah were back there watching television and did not see Cpl. Desmond when he entered the home. The medical examiners were not able to determine the exact order in which people were shot, but the evidence we have is that Brenda had time to make a phone call to her brother George and said something to the effect that Lionel had shot his wife and for him to get down there as soon as possible.

Cpl. Desmond then shot his mother and daughter in some order after which he removed the magazine out of the rifle, placed it on the counter, leaving only one bullet left in the gun and one for himself. Now Sgt. Rose-Berthiaume suggested that, as a firearms expert, Cpl. Desmond would have known that taking this action would make the gun safe in case anyone came upon it afterwards.

We have heard a great deal about dissociation in this Inquiry and this moment is one which calls it back to mind in an important way. We have heard of grounding yourself in reality or, to use the more common phrase, "snapping out of it". Nobody can imagine the intensity of such a moment for someone in Cpl. Desmond's position but it is far from unimaginable that the starting nature of such a revelation might have a very weighty grounding effect. It would seem then that the reality of his surroundings was to snap back to Cpl. Desmond and the gravity of what he had just done became apparent to him. He made the gun safe and then shot himself. One of his last thoughts or perhaps his very last thought was for the safety of others.

So many things do not add up, that do not fit, make one wonder whether this tragedy may have, in whole or in part, taken place while Cpl. Desmond was in a dissociative state, not in the

present time or place but, rather, back in Afghanistan fighting for his life against a ruthless and determined enemy.

Dr. Theriault said in his report that his initial opinion was that these homicides were what he described as a familicide/suicide, which is the term when the head of the household takes the lives of his family and himself. Dr. Theriault talked about ... and when he made his report, he applied the well-known Occam's razor theory that says the most simple and straightforward explanation is the most likely explanation.

In writing his report, Dr. Theriault had the benefit of reviewing material from the file. And I would suggest that not until he testified did he perhaps have the benefit of some of the particularly relevant contextual factors to do with dissociation. What he gave us was a description but not really an explanation. There is more depth and complexity to this case and it is important for anyone involved with the military to see what might be particular to that experience.

Occam's razor can often lead one to the proper conclusion. But there is another view encapsulated by a saying my former criminal law professor, Bruce Archibald, used to employ and which has been attributed to H.L. Mencken that says, "Every

complex problem has a solution which is simple, direct, plausible, and wrong."

Lionel Desmond's case was complicated, perhaps too complicated to make forensic psychiatric conclusions with a high level of certainty. But a finding by Your Honour that this tragedy might have been caused or exacerbated by a dissociative episode would go a long way towards ensuring this crucial issue is given the research time and attention the experts we have heard from agree it merits.

If we accept that Cpl. Desmond may have had dissociative experiences, the next question is, What is the most likely manifestation of that episode or disorder on January 3rd, 2017? When Cpl. Desmond returned to the Greencorn residence, changed into his camouflage clothing and drove to the woods road with his newly purchased rifle, this may have been the beginning of a prolonged dissociative episode.

If Cpl. Desmond was planning to threaten Shanna, hoping she would call off the breakup, perhaps the dissociation kicked in soon after he entered the house and the stress or pressure of the moment put him over the edge and triggered an episode. One may look even earlier to Cpl. Desmond's arrival back from Leaves & Limbs. If he was simply planning a dramatic confrontation,

knowing internally that he was not planning to follow through with it, or if he did not have a plan, there would be no need to get dressed in camouflage, sneak through the woods, or slash the tires to prevent Shanna's escape. Those actions are more consistent with a former soldier in a dissociative state who feels they're back in a war zone. In a way, Cpl. Desmond never really returned from Afghanistan.

The depth of the grief felt by the Desmond family after this tragedy was enormous and reverberated throughout Lincolnville and Guysborough through anyone with connection to the area, to the wider Canadian military family, and all who love our military. There were vigils, there were tears, and there were questions. The Desmond family were determined to summon the energy to push for those answers on behalf of military families and, indeed, all Canadians and it felt a tremendous support of many from across the country that understand the importance of the questions raised by this tragedy.

As it so happens, Mr. Long, Cpl. Desmond's teacher and track coach, also organizes the annual Remembrance Day ceremony in Guysborough. As part of this ceremony, a slideshow has been prepared and built upon which has photos of the many men and

women from the area who have served in the military going back as far as the First World War. Cpl. Desmond has been included in the slideshow and had, himself, previously taken part in the local ceremony.

I asked Mr. Long if he had ever been asked to remove Cpl. Desmond from that slideshow and what he would do if he was asked. Mr. Long said he had thought about that question himself but no one had brought it to him and knowing Lionel when he was the person that we all knew, he never considered taking it out. **(13:40)**

This was a clear answer from Mr. Long and displayed something that I think is quite important. We have seen many examples throughout the Inquiry of the love and affection that Cpl. Desmond's family had and still has for him, despite the horrific nature of what happened on that awful day. The wider community recognizes that these were tragic events in which Cpl. Desmond was the perpetrator in only the narrowest of senses. In a deeper, more meaningful sense, he was a victim as well, and the service that he provided for his country is still worthy of honour and respect. That is one way he will be remembered.

Perhaps he will also be remembered eventually as the tragic genesis of change for the better for our military personnel and

their families through the deliberations and recommendations from this Inquiry. Lionel Desmond was a victim of the service he gave to his country and far from the only one. Too many Canadian soldiers have followed a similar path with similar tragic consequences. Still others hover over that path and struggle on a day-to-day basis to find reasons to keep moving forward.

Both the Government of Nova Scotia and the Government of Canada owe these soldiers and their families the best support that Canadians can provide. It is the responsibility of this Inquiry to understand what happened to Lionel Desmond and others like him and to recommend what can be done to strengthen our military and prevent future tragedies.

Thank you, Your Honour, for listening to these remarks and for being attentive throughout these proceedings. It was an honour to take part in this important work and, hopefully, the contributions made by the personal representative to the late Cpl. Lionel Desmond have been insightful and helpful to you as you prepare your final report.

I'd like to thank Inquiry staff, court staff both here and in Guysborough, my colleagues, the many witnesses who have appeared here at the Inquiry and offered their testimony, and a

special thank you to Dr. Matthew Bowes who saw the need for a deeper look into these tragic events and took the actions required to initiate this Fatality Inquiry.

Cpl. Desmond's sister and personal representative, Cassandra Desmond, and the Desmond family remain committed to seeking change for the betterment of members of our military and their families and would welcome and accept further involvement in the implementation and oversight phases of this Inquiry.

Those are my remarks, Your Honour. I apologize for going longer than perhaps expected but thank you for your attention.

THE COURT: No, that's not a problem, Mr. Rodgers. Thank you for your comments today.

Mr. Murray, you don't have any further comments, do you?

MR. MURRAY: No, Your Honour.

THE COURT: All right. Thank you.

CLOSING REMARKS

THE COURT: So we've heard from everybody today and I want to thank you for your comments. I'm just going to make a couple of quick observations.

May 21st, 2019, we assembled in Guysborough and opened the Desmond Inquiry. Most of you were there that day. I don't think Mr. Macdonald was there that day, but I think he joined us shortly thereafter. At the time, Inquiry counsel was Mr. Murray, Mr. Russell, and Ms. Levangie and Ms. Acker, we were fundamentally the governing body, I guess, of the Inquiry, if we put it that way, and it was through the cooperation of counsel and a lot of hard work and a lot of effort on many, many people.

And I don't intend to deal with it all today, but I will be addressing it when I write the report, who were able to come together and design the document management system for us that was just really critical to being able to get the information out to everyone in a meaningful way so that we were all always on the same page as far as that went critical ... of critical importance.

The Inquiry did not proceed in a straight timeline. As we're all aware, we sat in Guysborough for a period of time and the pandemic effectively shut us down for almost a year and then we were forced by Public Health restrictions to move the Inquiry

here and then set up this room, and then proceeding. And we've had pandemic interruptions on a variety of occasions, as well, that have kind of slowed the work that we were all brought together to turn our attention to.

So it was through combinations of patience and cooperation and support that we're able to get to the last day, so to speak ... last day for perhaps some of you but certainly not for me and not for the support that continues in place. We know that Mr. Russell has moved on to Provincial Court bench and Ms. Levangie has taken retirement.

So we're left with ... not left with, I still have the support of Ms. Acker and Mr. Murray to the extent that I require that support as I go through the process of preparing the report. And it may very well be that Mr. Murray may be in contact with you if I require any clarification of any of the material that you have submitted by way of recommendations or if there's other clarifications that might be helpful to me and so Mr. Murray will be back in touch with you if that happens.

So thank you all for your participation and cooperation. Important to thank ... I appreciate the individual witnesses who took the time to attend, the time that was involved in preparation. Without them, we wouldn't have the evidentiary

picture that exists today, which is as I think Mr. Macdonald pointed out, allows me to turn my attention to an analysis and ultimately report some recommendations.

The **Fatality Investigations Act**, Section 39, provides that: "At the conclusion of the fatality inquiry, the judge shall make and file with the Provincial Court a written report containing any findings made by the judge as to ..."

And then there's a variety of items that are listed and we're all familiar with those. So this is, effectively, the closing of the Inquiry subject to being contacted by Mr. Murray for some clarifications.

It's difficult to predict how much time it might require to write the report. I will say that when it's done, or close to done, or completed and I have an idea of when it might be filed with the Provincial Court, counsel, all the participants will be contacted and you'll have notice that that's going to happen, so that no one will be caught by surprise. And although I haven't quite worked out yet how it will be generated to you, how it will be made available to the public, between now and that phone call or email, we'll have that all worked out.

So, once again, appreciate all the time and the effort you've put into the Inquiry and we'll close it out today then.

Thank you.

Sorry. Mr. Macdonald?

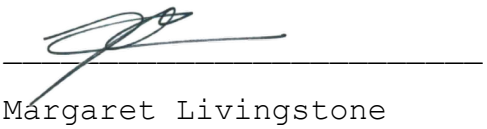
MR. MACDONALD: Your Honour, I just had one more thing. I've canvassed counsel and we're unanimous in wanting you to know that we know that you are about to start a well-deserved delayed retirement and we wanted to wish you the very best in retirement and to thank you for your service not only to the legal profession for your many years as a practicing lawyer but also to the people of the Province as a sitting judge for many years. And we wanted to say that to you because we mean it and also because we know you don't have your report out yet and we're still afraid of you, Your Honour, so all the best in the future, Your Honour, from all of us.

THE COURT: Thank you, Mr. Macdonald. Thank you.

COURT CLOSED (13:49 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 24, 2022