IN THE MATTER OF A FATALITY INQUIRY REGARDING THE DEATHS OF AALIYAH DESMOND, SHANNA DESMOND, BRENDA DESMOND AND LIONEL DESMOND

A Report Pursuant to the
Fatality Investigations Act

January 31, 2024

Paul B. Scovil
Provincial Court Judge

REPORT OF THE INQUIRY

INTO THE DEATHS OF THE DESMOND FAMILY

VOLUME I

Navigating This Report

Mental Health and Wellness

Sometimes reading about distressing or emotionally overwhelming information can be challenging, particularly for those who may have experienced trauma in their own lives. As you read this Report, please make sure to keep mental health and wellness in mind. If you or someone you know is in need of support, consider the resources listed below and outlined in this report, or check with your local health authority or the Canadian Mental Health Association at www.cmha.ca to find resources in your area.

- If you are experiencing distress or overwhelming emotions at any time, you can call the ***Nova Scotia Provincial Crisis Line 24/7 at 1-888-429-8167.*** You do not have to be in a crisis to call, and nothing is too big or too small a reason to reach out. The Nova Scotia Provincial Crisis Service can also provide the contacts for other crisis services that are available if you live outside Nova Scotia.
- If you or someone you know is struggling in any way, you can call 211 or visit **211.ca**. 211 offers help 24 hours a day in more than one hundred languages and will be able to connect you directly to the right services for your needs.
- The ***Kids Help Phone*** is a national helpline that provides confidential support at 1-800-668-6868 or text CONNECT to 686868.
- Additional supports for across Canada are available at *www.wellnesstogether.ca*

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Part I

Introduction and Preface

Introduction

This Inquiry has its roots in the tragic life of Corporal Lionel Desmond, his service to his country in Afghanistan, his family including his daughter Aaliyah, his wife Shanna, his mother Brenda, and his spiral into mental illness. His mental health led to the deaths of his family and himself along with the heart-rending ripple effect to the lives of his extended family, friends and community.

It is a history of a soldier's Post Traumatic Stress Disorder (PTSD), intimate partner violence and a cascade of events ultimately leading to Corporal Desmond shooting his daughter, wife, and mother before turning his weapon on himself. It is a story of mental health systems encased in silos built over cracks.

As I write this report, my sympathy and heartfelt sadness goes out to those family members and the community left behind, and the anguish they no doubt feel regarding the events of January 3, 2017. I especially wish to thank those individuals who continued to press for this Inquiry in the hopes of obtaining answers and healing in the aftermath of this tragedy.

Corporal Desmond purchased a rifle on January 3, 2017, and proceeded, as set out above, to take the life of his family and himself. This Inquiry cannot change the past, but the expressed desire of this writer is that the review and recommendations of the Inquiry will go towards the prevention of further such tragic events and that the ability of those who serve their country will have the best mental health care that we owe them irrespective of where they choose to live after service.

Corporal Desmond was described as a happy, energetic young person who liked hard work and was always seen with a smile. He was noted to be a humorous person with an outgoing personality.[1] He met and married his wife Shanna at a young age. The two married shortly after Shanna graduated from high school and their only child Aaliyah was born on December 28, 2006.

Seeking stable employment Corporal Desmond joined the military on September 23, 2004, and was deployed to Afghanistan on January 31, 2007**.** Aaliyah was just newly born. There is no question that when Corporal Desmond returned from his tour of duty he was an ill and changed man suffering from acute PTSD.

This Fatality Inquiry was called at the order of the Minister of Justice, the Honourable Mark Furey on the 14th day of February 2018 pursuant to the *Fatality Investigations Act,* S. N. S. 2001, c. 31. The order stipulated the judge appointed to conduct the Inquiry shall make and file with the Provincial Court a written report containing any findings made by that judge as to the fatalities of Aaliyah Desmond, Shanna Desmond, Brenda Desmond, and Corporal Lionel Desmond including the following:

(i)a. The date, time, and place of death;

The cause of death;

The manner of death; and

The circumstances under which the death occurred including:

[1] Transcript Paul Long – February 17, 2021 - Page 15

(i) The circumstances of Lionel Desmond's release from St. Martha's Regional Hospital on January 2, 2017;

(ii) Whether Lionel Desmond had access to appropriate mental health services, including treatment for occupational stress injuries;

(iii) Whether Lionel Desmond and his family had access to appropriate domestic violence intervention services;

(iv) Whether healthcare and social services providers who interacted with Lionel Desmond were trained to recognize the symptoms of occupational stress injuries or domestic violence;

(v) Given Nova Scotia administration of the Canadian firearms program, whether Lionel Desmond should have been able to retain, or obtain a licence, enabling him to obtain or purchase a firearm;

(vi) What restrictions, if any, applied to accessing federal health records of Lionel Desmond by provincial health authorities or personnel; and

(vii) Any recommendations of the judge about the foregoing matters.

This report consists of three volumes.

Volume I, Part I includes this introduction and preface.

Part II will speak to the date, time, and place of death of the Desmond family. It will also describe the cause and manner of death.

Part III examines Corporal Desmond's release from St. Martha's Regional Hospital.

Part IV will explore whether Corporal Desmond had access to appropriate Mental Health Services, including treatment for Occupational Stress Injuries.

Part V will explore whether Corporal Desmond and his family had access to appropriate intimate partner violence intervention.

Part VI addresses whether Health Care and Social Services providers who interacted with Corporal Desmond were trained to recognize the symptoms of Occupational Stress Injuries (OSI) or Intimate Partner Violence.

Part VII asks given Nova Scotia Administration of Canadian Firearms Program – whether Corporal Desmond should have been able to retain, obtain or purchase firearm.

Part VIII assesses Federal Health Records of Lionel Desmond by provincial health authorities' personnel.

Part IX will contain acknowledgements and conclusion.

Volume II contains the Order of the Minister of Justice, List of counsel, Rules of Procedure, List of Experts, List of Witnesses, Inquiry Rulings, Medical Reports, List of Acronyms and a List of Recommendations.

Volume III will contain the Timeline of Events.

The Writing of this Report

The Inquiry heard testimony from a large number of witnesses regarding the background of the Desmond family, the lengthy and detailed history of the difficulties faced by Corporal Desmond regarding his mental health after having served in Afghanistan as well as the professionals who treated him.

A great deal is owed by me to others in completing this report. First and foremost, to the Honourable Judge Warren Zimmer who preceded me as Inquiry Judge, counsel for the Inquiry Allen Murray, K.C.; and now the Honourable Shane Russell, who was appointed to the Provincial Court during the Inquiry; as well as those counsel who made submissions. I will undoubtedly say more later in this report, but those individuals who toiled in the background, including support staff Selena Acker and Elise Levangie and many other individuals who assisted in the technical aspects of ensuring proper courtrooms and technological requirements that made this Inquiry possible.

Having said the above, the responsibility for any errors, deficiency or oversights are exclusively mine. I have attempted to make this report accessible to anyone who should decide to read it. I can indicate that the evidentiary background to this report is lengthy and detailed. Where necessary, the report will be referenced by notations relating to the testimony relied on and the evidence presented to the Inquiry

Preface

Short History of Events

Corporal Desmond grew up in Guysborough County, Nova Scotia. He was raised in a family of five siblings by a single, hard-working mother.

Corporal Desmond is described by his high school coach as someone people wanted to have on their team. He was an average student. His coach Paul Long described him as being liked and respected by his peers as someone who would do well in whatever avenue of life he chose.

His sister, Cassandra, described Corporal Desmond as the comedian of the household growing up. [2] His personality shows, through the witnesses, as one of honour, active in the community, quick to assist those family members in need. [3]

Corporal Desmond married Shanna Borden shortly after she graduated from high school. They had dated in high school. Their daughter Aaliyah was born on December 28, 2006**.** In order to better provide a stable income for his family Corporal Desmond entered the military. In doing so he followed a strong family tradition of service to their country. Corporal Desmond was posted to active duty in Afghanistan on January 31, 2007. It was during this time that he witnessed many difficult things.

Corporal Desmond returned from Afghanistan a broken man. He was diagnosed with PTSD in 2011, together with a Major Depressive Disorder (MDD). Eventually he received a medical discharge from the Canadian Armed Forces (CAF).[4] He was treated

[2] Transcript – February 16, 2021 – Page 23
[3] Ibid – Page 23
[4] Exhibit P-000301

for his mental illness both prior to and after his discharge. This included intensive multidisciplinary treatment at Ste. Anne's Hospital in Montreal.

Corporal Desmond's mental health continued to deteriorate. On January 1, 2017, an incident with his wife's truck being put off the road, while he was driving, triggered Corporal Desmond's mental health. He attended St. Martha's Regional Hospital in Antigonish during the day of January 1, 2017, where he was admitted on overnight social observation. He also saw an on-call doctor and psychiatrist. He voluntarily checked out the next day. He obtained a firearm, lawfully, a Russian SKS-AR rifle on the afternoon of January 3, 2017. In the early evening of January 3, 2017, Corporal Desmond shot and killed his wife, daughter, mother and then himself.

His domestic situation with his wife Shanna had become fraught with difficulty and torment. His wife Shanna had remained, for the most part, in Guysborough County, Nova Scotia, while Corporal Desmond was in the Armed Forces. She was able to pursue a nursing degree and was employed as a nurse at St. Martha's Regional Hospital. The domestic relationship between her and her husband was strained and turbulent.

There had been several separations prior to January 3, 2017. That evening Shanna was home when the tragic shooting occurred.

The daughter of Shanna and Corporal Desmond, Aaliyah was age 10 at the date of her death. She was a happy child involved with school and other activities. She had called her aunt Chantel Desmond between 4:20 p.m. and 4:30 p.m. on January 3, 2017, to pick her up at about 6:00 pm to attend CAP tutoring in Lincolnville. It was her aunt who first discovered the tragic shooting.

Corporal Desmond's mother, Brenda Desmond, was a single mother who raised five children. The descriptions of her show a hard-working woman who was described as the glue that held the family together. [5] She and her sister Linda worked for Miller Construction. She was a flagger for that company. She was living with Corporal Desmond, Shanna and Aaliyah and was home on the night of the tragedy. She was able to call her brother, George Desmond, at about 6:00 pm on January 3, 2017, telling him that Corporal Desmond had just shot Shanna. Brenda was subsequently shot and killed by her son.

[5] Transcript – February 16, 2021 – Page 26

History of Inquiry Proceedings

Dr. Matthew Bowes has been the Chief Medical Examiner (CME) for the Province of Nova Scotia since 2006. Between January 3, 2017, and October 13, 2017, Dr. Bowes had reviewed the circumstances surrounding the deaths of the Desmond family as well having spoken with surviving family members. As a result, Dr. Bowes wrote several letters to the then Attorney General, The Honourable Mark Furey, recommending that an Inquiry be held into the deaths of the Desmond family.[6] The last letter from Dr. Bowes to Attorney General Furey was December 28, 2017.

On February 14, 2018, The Honourable Mark Furey ordered this Inquiry pursuant to Section 27(1) of the *Fatality Investigations Act*. It was ordered that:

1. A fatality Inquiry shall be held regarding the Desmond deaths.
2. The Chief Judge of the Provincial Court of Nova Scotia shall appoint a judge to conduct the Inquiry in accordance with subsection 27(3) of the *Act*.
3. The Judge appointed to the Inquiry shall make and file with the Provincial Court, a written report containing any findings by the Judge as to:
   (a) the date, time, and place of death;
   (b) the cause of death;
   (c) The manner; and
   (d) The circumstances under which the deaths occurred, including:
      (i) the circumstances of Lionel Desmond's release from St. Martha's Regional Hospital on January 2, 2017;

[6] Exhibit –P-000014
P-000015
P-000016
P-000017

(ii) whether Lionel Desmond had appropriate mental health services, including treatment for Occupational Stress Injuries (OSI);

(iii) whether Lionel Desmond had access to appropriate Violence Intervention services (VIS);

(iv) whether health care and social services providers who interacted with Lionel Desmond were trained to recognize the symptoms of Occupational Stress Injuries (OSI) or Domestic Violence (DV);

(v) given Nova Scotia administration of the Canadian Firearms Program, whether Lionel Desmond should have been able to retain, or obtain a licence enabling him to obtain or purchase a firearm;

(vi) what restrictions, if any, applied to accessing federal health records of Lionel Desmond by provincial health authorities or personnel; and

(vii) any recommendations of the Judge about the foregoing matters.

As a result of the above orders, the Honourable Pamela Williams, Chief Judge of the Provincial Court appointed the Honourable Warren Zimmer as the presiding judge. Following that was the appointment of Allen Murray, K.C., and Shane Russell (as he was then) as counsel to the Inquiry.

Opening remarks were held on May 21, 2019, at facilities renovated in Guysborough to house the Inquiry. Preliminary applications were heard regarding participants to the Inquiry pursuant to section 36 of the *Fatality Investigations Act*. Judge Zimmer began hearing evidence on January 27, 2020, and continued until March 2, 2020.

Due to safety requirements the proceedings of the Inquiry were interrupted by the Covid-19 Pandemic. Hearings were adjourned until a Covid-19 compliant courtroom, was available in the Justice Centre in Port Hawkesbury, Nova Scotia. A total of 52 days of hearings took place with final submissions occurring before Judge Zimmer on April 20, 2022.

Before Judge Zimmer could complete the report of the Inquiry, he became unable to do so due to his reaching the age limitation for sitting Judges. Given Judge Zimmer's

inability to complete the report, Chief Judge Pamela Williams appointed myself, retired Judge Paul Scovil as presiding Judge pursuant to Section 38 of the *Fatality Investigations Act*.

Scope and Mandate of Inquiry

As indicated this Inquiry was ordered pursuant to the Ministerial Order of February 14, 2018. The mandate of this Inquiry is prescribed by that order including the ability to make any recommendations regarding the circumstances arising out of the deaths of the Desmond family.

The findings and recommendations must, of course, be grounded in the evidentiary background provided by the witnesses who have appeared and testified, and the reports tabled with the Inquiry. I shall endeavour wherever needed to footnote and refer to those evidentiary underpinnings.

Regarding Findings of Legal Responsibility

It is clear from Section 39(2) of the *Fatality Investigations Act* that my findings "shall not contain any findings of legal responsibility." While some may believe that those type of findings should occur, the purpose of the Inquiry was to hear fulsome evidence regarding its mandate and report back to government with findings and recommendations which are to assist in providing the government with guideposts to avoid a situation such as occurred on that awful evening on January 3, 2017.

In that regard, I quote then Judge Anne Derrick, now Justice Derrick, in the Hyde Inquiry where she stated the following:

> First of all, the principle of fairness that must characterize any inquiry requires that hindsight be applied appropriately, to recommendations, which must be forward-looking, and not to the actions (or inactions) and decisions that were made. As observed by Professor Ratushny:
>
>> Justice Campbell [Review of the Paul Bernardo investigation] drew a distinction between formulating recommendations, where hindsight is essential, and assessing past conduct, where hindsight is unfair: "The only fair way to review past conduct is to avoid hindsight. The only fair way is to put yourself in the shoes of the person who had to make the decision. What did they know when they decided to quit a particular line of investigation? What did they know and what did they think when they failed to report a particular incident?"
>
> However, this does not preclude identifying from the facts where a decision or action/inaction constitutes a failure to satisfy the appropriate standard of performance. A reference to the "failure" to do something that should have been done is not a finding of civil liability. "...there are many different types of normative standards, including moral, scientific, and professional-ethical. To state that a person "failed" to do something that should have been done does not necessarily mean that the person breached a criminal or civil standard of conduct. The same is true of the word "responsible."
>
> Inquiries are not trials and do not offer the evidentiary or procedural safeguards available in a trial. They are inquisitorial, not adversarial.

> The "primary role, indeed the raison d'etre, of an inquiry investigating a matter is to make findings of fact."[16] A judge conducting an inquiry "has the power to make all relevant findings of fact necessary to explain or support the recommendations even if these findings reflect adversely upon individuals…"

This Inquiry, as well, will not make any significant findings of any individual failures or shortcomings, but will rather provide what recommendations to ensure that those who find themselves in similar positions as Corporal Desmond and his family might be saved from further tragedy.

PART II

Date, Time, and Place of Death

Date, Time, and Place of Death, and Identity of the Deceased

Pursuant to the *Fatality Investigations Act* S. 39(1) (a), (b)(c)(d) and (e) as well as the Ministerial Order which created this Inquiry, I am mandated to report any findings as to the identity of the deceased, the date, time and place of deaths, the cause of deaths and manner of deaths of the Desmond family. Evidence before this Inquiry regarding the circumstances of the deaths covered many difficult, complex, and challenging issues. These are explored elsewhere in this report. The date, time, place of death, cause of death and manner of death were not hard to determine.

The time of death can be placed with a fair degree of accuracy at or about 6:00 p.m. on the evening of January 3, 2017.

Corporal Gerard Rose-Berthiaume of the Royal Canadian Mounted Police Northeast Major Crime Unit was the lead investigator regarding the deaths of Aaliyah, Shanna, Brenda, and Lionel Desmond. Corporal Rose-Berthiaume referenced a statement from George Desmond who described a call from his sister Brenda Demond at approximately 6:00 pm on January 3, 2017. [7] Brenda Desmond told her brother that Corporal Desmond had just shot his wife Shanna. [8]

Chantel Desmond had testified that she had received a call at about 4:20 p.m. to 4:30 p.m. from her niece Aaliyah requesting that she pick her up for an after-school activity for some time after 6:00 pm. When she arrived at the Desmond home at 6:00 p.m., she found Shanna, Brenda, Aaliyah, and Corporal Desmond all deceased.[9] Chantel

[7] Transcript – January 29, 2020 – Page 64-65
[8] Ibid – Pages 64-65.
[9] Transcript – February 17, 2021, pages 102-104

testified that she understood that the after-school activity was not taking place but would pick up her niece anyway in order that they could spend some time together.

On arrival Chantel entered the home and could hear the dog barking. She observed Shanna on the floor with blood pooling underneath her. She saw her brother, Lionel, and saw that there was a hole in his head. [10] She then ran out of the home. While outside the home, her mother's twin sister Linda arrived. Other family members were contacted, and a 911 call was made.

Staff Sergeant Addie MacCallum of the Royal Canadian Mounted Police (RCMP) testified that a call came from his dispatch centre in Truro. This call had been received by him at the (RCMP) Guysborough Detachment at 6:00 p.m. on the evening of January 3, 2017. The call generated from 911 indicating that there was a suicide in progress. The use of the words "suicide in progress" seemed unusual to Staff Sergeant MacCallum. Usually, someone either is reported to have committed suicide or is suicidal. Staff Sergeant MacCallum was directed to attend the residence at 15375 Highway 16 in Upper Big Tracadie, Guysborough County, Nova Scotia, owned by the Borden family and where the Desmonds resided.

Staff Sergeant MacCallum attended together with Constable Nathan Sparks at the residence in Upper Big Tracadie. The officers were advised that the 911 call was received from Chantel Desmond, a sister of Corporal Desmond at 6:03 p.m. She was in a very distraught state. [11] The two officers attended at the residence where they found all four members of the Desmond family deceased.

[10] Transcript – February 17, 2021, Page 105
[11] Exhibit – P-000023

From the evidence it would appear that Corporal Desmond first shot his wife, Shanna. He would have then shot his mother, Brenda, and Aaliyah. Finally, he would have turned his gun on himself. We know this order partially as Brenda Desmond called at about 6:00 p.m. to report that "Lionel had just shot Shanna."

The attending RCMP officer contacted the Medical Examiner's office that evening. The Inquiry heard testimony from Dr. Erik Mont, the Deputy Chief Medical Examiner for the Province of Nova Scotia. Dr. Mont, together with his team, attended the scene in Upper Big Tracadie. Dr. Mont completed reports of the Post-Mortem Examinations and Medical Certificates of Death for each of the deceased. [12]

Doctor Mont, in his testimony, provided that "cause of death" is defined as the disease or injury that, in an unbroken chain of events, ultimately leads to an individual's death. He went onto explain that the manner of death involves a classification system containing five categories. Those categories include homicide, suicide, accident, natural and undetermined. [13]

In the case of each of the four decedents, the date of death was January 3, 2017, at or about 6:00 pm. The place of death was the residence located 15375 Highway #16, in the community of Upper Big Tracadie, Guysborough County, Nova Scotia.

With respect to Shanna Desmond, the cause of death was determined to be "gunshot wounds to the neck, chest and abdomen."[14] The manner of death was

[12] Exhibits –P-000045 – Postmortem Examination of Aaliyah Desmond
P-000046 – Medical Certificate of Death, Aaliyah Desmond
P-000050 – Amended Postmortem Examination of Brenda Desmond
P-000051 – Medical Certificate of Death of Brenda Desmond
P-000055 – Amended Postmortem Examination of Lionel Desmond
P-000056 – Medical Certificate of Death of Lionel Desmond
P-000061 – Postmortem Examination – Shanna Desmond
P-000062 - Medical Certificate of Death Shanna Desmond

[13] Transcript – January 30, 2020 – Page 13

[14] Exhibits – P-000045, P-000046, P-000050, P-000051
P-000055, P-000056, P-000061, P-000062

homicide. With respect to Brenda Desmond, the cause of death was a "gunshot wound of the chest." The manner of death was homicide. With respect to Aaliyah Desmond, the cause of death was "gunshot wound of the face, neck and chest." The manner of death was homicide. With respect to Corporal Desmond the cause of death "gunshot wound of head." The manner of death was suicide.

PART III

Circumstances of Lionel Desmond's release from St. Martha's Regional Hospital on January 2, 2017

Circumstances of Lionel Desmond's release from St. Martha's Regional Hospital on January 2, 2017

Mr. Desmond attended the Emergency Department of St. Martha's Regional Hospital on the evening of January 1, 2017. He was seen by Dr. Justin Clark in the Emergency Room. [15] He was then seen by the on-call psychiatrist Dr. Faisal Rahman.

There has existed misunderstanding and confusion regarding Corporal Desmond's short stay at St. Martha's Regional Hospital. Unfortunately, there was a belief held by both family and the community that when Corporal Desmond had sought help on January 1, 2017, at St. Martha's Regional Hospital, the hospital had turned him away and he was left unseen by medical professionals. Understandably this left the family bearing considerable pain and frustration. This may have been caused, in some respects, by Corporal Desmond himself. Corporal Desmond himself called Clinical Care Manager (CCM), Helen Luedee on January 2, 2017. He reported to her "I went to the hospital they said I didn't need to be there, and it didn't help."[16] Corporal Desmond also spoke with his uncle whom he told that he had gotten out of the hospital that morning.[17] At the end of the day, it is unknown the source of the narrative that Corporal Desmond was turned away from St. Martha's Regional Hospital, but it is clear that was not the case.

Corporal Desmond attended at the Emergency Department on the evening of January 1, 2017, at which time he was seen by Dr. Justin Clark. Doctor Clark's curriculum vitae was introduced as an Exhibit. He attended at the University of Ottawa followed by an Emergency Medicine residency at Dalhousie University.

[15] Exhibit –P-000067
[16] Exhibit – P-000288
[17] Transcript –March 25 ,2021 – Page 35-38

Corporal Desmond was unknown to Dr. Clark on January 1, 2017. Corporal Desmond advised Dr. Clark that he suffered from PTSD. Dr. Clark was also told by Corporal Desmond that his wife had asked him to leave the home and not return until the next day.[18] It was Dr. Clark's opinion that Corporal Desmond should be seen by a psychiatrist.

Evidence was provided that St. Martha's Regional Hospital was staffed by a psychiatrist either on site or on call 24 hours a day, seven days a week. On January 1, 2017, the on-call psychiatrist was Dr. Faisal Rahman. Dr. Rahman is the Chief of Psychiatry and Clinical Director at St. Martha's Regional Hospital and also serves as the Chief of Psychiatry for the Eastern Zone of the Nova Scotia Health Authority (NSHA). [19]

Dr. Rahman's chart regarding Corporal Desmond indicated that Corporal Desmond was a retired CAF veteran who had fought in Afghanistan and as a result had a diagnosis of PTSD. Corporal Desmond advised Dr. Rahman that he was being followed by Dr. Ian Slayter. While the doctor ascertained that Corporal Demond continued to suffer from PTSD, he also confirmed that Corporal Desmond denied any suicidal or homicidal ideations.

Dr. Rahman had considered the possible admission of Corporal Desmond under the *Involuntary Psychiatric Treatment Act,* 2005, c. 42.

Under the *Involuntary Psychiatric Treatment Act,* a patient may be admitted to a psychiatric facility as either a voluntary or involuntary basis. In relation to the voluntary admission, the Act states as follows:

[18] Exhibit – P-000067 – Page 33
[19] Exhibit – P-000068

VOLUNTARY ADMISSION

Voluntary patient

4. A psychiatrist who has examined a person and who has assessed the person's mental condition may admit the person as a voluntary patient of a psychiatric facility if the psychiatrist is of the opinion that the person would benefit from an in-patient admission. 2005, c. 42, s. 4.

Assessments of capability to consent

5 Any assessments of the capability of a voluntary patient to consent to treatment or the appointment of a substitute decision-maker shall be carried out pursuant to the relevant provisions of the Hospitals Act. 2005, c. 42, s. 5.

Voluntary patient may consent

6 Subject to Section 7, a voluntary patient who is capable of consenting to admission or discharge from a psychiatric facility may do so or a substitute decision-maker may do so on behalf of the patient. 2005, c. 42, s. 6.

Detention of voluntary patient

7. (1) A member of the treatment staff of a psychiatric facility may detain and, where necessary, restrain a voluntary patient requesting to be discharged if the staff member believes on reasonable grounds that the patient

(a) has a mental disorder;

(b) because of the mental disorder, is likely to cause serious harm to himself or herself or to another person or to suffer serious mental or physical deterioration if the patient leaves the psychiatric facility; and

(c) needs to have a medical examination conducted by a physician.

(2) A patient who is detained under subsection (1) must be examined by a physician within three hours. 2005, c. 42, s. 7.

As to the question of involuntary admissions the Act goes on to say the following regarding the ability of a physician to commit a person on an involuntary basis:

MEDICAL EXAMINATON AND
INVOLUNTARY PSYCHIATRIC ASSESSMENT

Certificate for involuntary assessment

8. Where a physician has completed a medical examination of a person and is of the opinion that the person apparently has a mental disorder and that

(a) the person, as a result of the mental disorder,

(i) is threatening or attempting to cause serious harm to himself or herself or has recently done so, has recently caused serious harm to himself or herself, is seriously harming or is threatening serious harm towards another person or has recently done so, or

(ii) as the result of the mental disorder, the person is likely to suffer serious physical impairment or serious mental deterioration, or both; and

(b) the person would benefit from psychiatric inpatient treatment in a psychiatric facility and is not suitable for inpatient admission as a voluntary patient, the physician may complete a certificate for involuntary psychiatric assessment for the person. 2005, c. 42, s. 8.

The Act also deals with a psychiatrist's ability to commit someone on an involuntary basis in Section 17. That section states:

INVOLUNTARY ADMISSION

Admission as involuntary patient

17. Where a psychiatrist has conducted an involuntary psychiatric assessment and is of the opinion that

(a) the person has a mental disorder;

(b) the person is in need of the psychiatric treatment provided in a psychiatric facility;

(c) the person, as a result of the mental disorder,

(i) is threatening or attempting to cause serious harm to himself or herself or has recently done so, has recently caused serious harm to himself or herself, is

> seriously harming or is threatening serious harm towards another person or has recently done so, or
>
> (ii) is likely to suffer serious physical impairment or serious mental deterioration, or both;
>
> (d) the person requires psychiatric treatment in a psychiatric facility and is not suitable for inpatient admission as a voluntary patient; and
>
> (e) as a result of the mental disorder, the person does not have the capacity to make admission and treatment decisions, the psychiatrist may admit the person as an involuntary patient by completing and filing with the chief executive officer a declaration of involuntary admission in the form prescribed by the regulations. 2005, c. 42, s. 17.

Neither Dr. Clark nor Dr. Rahman had information before them regarding Corporal Desmond that met the criteria set out in the *Involuntary Psychiatric Treatment Act*. In short, they had no reason, medically or legally, to detain Corporal Desmond as an involuntary patient.

Based on the information available to Dr. Rahman, his opinion rejecting involuntary admission was reasonable. Mr. Desmond indicated that he wished to stay in the hospital that night in order to "rest and reflect" in the words of Dr. Rahman. Corporal Desmond was then provided the opportunity to stay at St. Martha's Regional Hospital as what was termed a "social admission."[20] Dr. Rahman had reviewed the outpatient consultation report completed by Dr. Slayter. That report assessed Corporal Desmond's risk of suicide as "Low."[21] As well, Mr. Desmond himself reported having no intentions to hurt himself or others.

[20] Transcript – Dr. Rahman – February 4, 2020 – Page 41
[21] Ibid – Page 49

Through the night, the nursing staff reported that Corporal Desmond had slept poorly.[22] In the morning, Corporal Desmond indicated he wished to be discharged. Dr. Rahman was of the opinion that Mr. Desmond was able to be discharged. Accordingly, Corporal Desmond left St. Martha's Regional Hospital with advice to follow up with an appointment with Dr. Slayter.

There appears to be no evidence before this Inquiry to suggest that Corporal Desmond's interaction with the staff of St. Martha's Regional Hospital was anything but appropriate from a medical treatment point of view.

The interaction by Corporal Desmond with health care professionals on the evening of January 1, 2017, and into the next morning revealed a number of intimate partner violence risk factors in his personal life. He reported suffering from PTSD, his domestic life was troubled, and he also reported many outbursts.

It is purely speculative to wonder what would have happened at St. Martha's Regional Hospital on that occasion if they had been fully apprised of Mr. Desmond's medical history and if they had a fulsome opportunity to discuss the matter with Shanna Desmond.

The Inquiry had repeatedly heard that professionals dealing with Corporal Desmond may not have fully grasped the numerous red flags for the risk of serious intimate partner violence or domestic homicide. Training in this area for all health care professionals may assist in recognizing the risk factors for intimate partner violence and providing them with the proper tools to act.

[22] Exhibit –P-000067 – Page 34

Part IV

Whether Lionel Desmond had access to appropriate Mental Health Services, including treatment for Occupational Stress Injuries

Whether Lionel Desmond had access to appropriate Mental Health Services, including treatment for Occupational Stress Injuries

After deployment to Afghanistan, Mr. Desmond suffered prolonged and complex mental health challenges. These challenges were pernicious and required consistent, structured, and comprehensive mental health treatment if he were to maintain any measure of stability and conduct his daily life with any sort of functionality. These services were available to him at times. At other times they were not.

Corporal Desmond entered the CAF on September 23, 2004. He served in the Afghan conflict from January to August 2007. While in Afghanistan Corporal Desmond experienced the horrors of combat. While the Inquiry heard limited testimony about his combat duty, it clearly was traumatic. In 2010 Corporal Desmond was posted to the Musical Pipe-and-Drum Unit[23].

On September 28, 2011, Corporal Desmond was referred to Dr. Vinod Joshi. Dr. Joshi diagnosed Corporal Desmond with PTSD with Major Depressive Episodes (Operational).[24] It appears Mr. Desmond had been struggling with symptoms of PTSD for the last three to four years. Dr. Joshi treated Corporal Desmond pharmacologically and given Corporal Desmond's very limited understanding of PTSD, Dr. Joshi referred Corporal Desmond to Trauma Focused Psychotherapy and a Psychoeducational Group.[25]

[23] Transcript – Orlando Trotter – Page 78
[24] Exhibit – P-000183 – Page 3
[25] Exhibit – P-000173 – Pages 1,3 and 4

Between 2011 and 2015 Dr. Joshi saw Corporal Desmond 32 - 33 times during which his presentation, conditions and symptoms would vary. [26]

Therapeutically, Corporal Desmond was treated by Psychologist Dr. Wendy Rogers. Dr. Rogers worked with Corporal Desmond throughout December 2011 until February 2013. She utilized a prolonged exposure therapy approach. This approach had some success to the point where Corporal Desmond's symptoms had subsided sufficiently that medically he was cleared return to active duty.[27]

His symptoms were unfortunately triggered later in 2013 by an incident where he was subjected to racial comments by a colleague.[28] Corporal Desmond's struggle with PTSD continued for the remainder of his time with CAF.

In the spring of 2015 Corporal Desmond began transition from being an active member of the CAF to being discharged on medical grounds. The discharge had taken place when Corporal Desmond was at Camp Gagetown in New Brunswick.

On February 19, 2015, in anticipation of his being discharged from the CAF, Corporal Desmond attended the base in Gagetown to request a "rehab application". This would access a transitional program through Veterans Affairs Canada (VAC) which would include a case manager. Case managers do multiple things, with the focus of their work being accompanying veterans who are facing barriers in their transition into civilian life. Case managers basically inherit their caseload with a number of veterans.

While Corporal Desmond himself was clearly being proactive, he was told he would not be able to take advantage of the transitional program until after his formal

[26] Transcript – February 23, 2011 – Page 75
[27] Exhibit – P-000222
[28] Exhibit – P-000-223

release. This resulted in a delay of four months before VAC could begin the process of assessing, evaluating, and coordinating resources for Corporal Desmond, including the provision of an assigned case manager. This is the first significant delay in obtaining a pathway to appropriate mental health services.

Corporal Desmond met and was assessed by CAF Nurse Kimberly Bates on April 13, 2015. She noted his medical release from the CAF was set for June 16, 2015. This generated her report.[29] The report states, in part as follows:

> 1. Member noted that he has decided that he is going to sell the house here despite relationship uncertaintly [*sic*] and plans to meet with a Real Estate Agent next week.
>
> 2. Member noted that his spouse states [*sic*] is still completing her nursing studies in NS and reports that she is still unsure what she wants to do as far as their relationship goes.
>
> 3. Member noted that she has do [*sic*] an upcoming practicum at the IWK to complete her Nursing Program and is unable to think about anything else at this time. Member noted that he has sought out counselling by himself.
>
> 4. Member reports that he was awarded for PTSD with MDD symptoms.
>
> 5. Member will need to secure a family doctor. Member is aware how to access waitlist and of resource to acess [*sic*] care in interim
>
> 6. … he has obtained Rx for Medicinal Marijuanna [*sic*] but has not yet obtained as he would have to pay out of pocket for same. Member is still considering for future if VAC will cover upon his release.

There was no evidence that this document was shared with Corporal Desmond or any other service provider outside of the CAF. In her testimony before the Inquiry, Corporal Desmond's case manager Marie-Paule Doucette agreed that there would be value in the sharing of the above in his transition to civilian life. The problems related to

[29] Exhibit – P-000301

informational sharing between agencies and medical personnel is one that will pervade the provision of medical services to Corporal Desmond throughout the remainder of his life.

On April 16, 2015, Corporal Desmond requested a “myVAC” enrollment code in order to access a myVAC account.[30] The myVAC account contains information from Veteran’s Affairs regarding resources, support, and benefits, along with the various forms and applications necessary to access those services.

Corporal Desmond attended three times at CAF Base Gagetown seeking assistance in opening and navigating the myVAC account. [31] His case manager Marie-Paule Doucette testified that the operation of the myVAC account and how VAC operates are not simple things to learn.[32] Ms. Doucette went on to say that she never discussed his myVAC account with Corporal Desmond. There was no evidence that Corporal Desmond ever brought up the subject with his case manager.

In Canada, Federal and Provincial Governments may only create public Inquiries into matters within their respective legislative jurisdictions.

It is recognized that provincial inquiries cannot make recommendations to federal entities. If I could make such recommendations, they would include that where armed forces members are transitioned out of the forces due to medical health issues special care be taken to ensure such members can navigate the myVAC program.

[30] Exhibit –P-000273 – Page 20
[31] Ibid – Page 19, 20
[32] Transcript – June 23, 2021 – Page 12

Corporal Desmond maintained a home in Oromocto, New Brunswick. Upon release from the CAF, he was referred to New Brunswick OSI Clinic. At that facility Corporal Desmond had access to treating psychiatrist Dr. Anthony Njoku and a psychologist, Dr. Mathieu Murgatroyd. This access to treatment continued between June 2015 and May 2016.

Corporal Desmond was triaged for the New Brunswick OSI Clinic by Nurse Christine Lillington. [33] The triage notes showed Corporal Desmond advised he was not doing well regarding mental health and was wanting to engage in therapy as well as see a psychiatrist post-release.

Corporal Desmond was contacted by Dr. Mathiew Murgatroyd, from the OSI Clinic on June 8, 2015. An initial appointment was set for June 22, 2015. Corporal Desmond missed that appointment and was contacted by Dr. Murgatroyd regarding the missed appointment. Dr. Murgatroyd was able to arrange for a replacement session two days later on June 24, 2015. [34]

In the two months since transitioning from military to civilian life, there had been limited contact or treatment with mental health professionals. There was a brief triage interview with Nurse Lillington. Corporal Desmond also attended on May 25, 2015, for a "Transition Interview" with CAF. He was noted as moderate risk for transitioning to civilian life, and he also reported difficulties with his mental health.[35] A work order was

[33] Exhibit – P-000244 –Pages 8 – 10 and 81
[34] Ibid – Page 82
[35] Exhibit – P-000278

placed on the same day for a referral of the case to a case manager for case management and rehab program support.[36]

Corporal Desmond was not assigned to a case manager for a full six months. The evidence at the Inquiry made it clear that with patients suffering from PTSD and mental health issues, a prompt and seamless transfer between clinicians are crucial. This did not happen for Corporal Desmond. The VAC case manager finally assigned to him, Marie-Paule Doucette, received the work order assigning her on the November 26, 2015.[37] Ms. Doucette was not able to speak to the reason for the Departmental delay, but her testimony showed that VAC faced an increased demand with a number of new hires for case managers. There also appeared to be some retirements within the category of employees. Ms. Doucette outlined that she underwent four to five weeks training before she picked up new assignments. [38] Corporal Desmond was one of her first clients.

As indicated previously, Corporal Desmond had been in the care of the OSI clinic since late June 2015. While without a case manager, Corporal Desmond was not without mental health care. There can be no question, however, that an early attachment to a case manager could have assisted in Corporal Desmond, by having a stabilizing influence and improved in dealing with VAC.

1. ***Recommendation: It is recommended that the Provincial Government of Nova Scotia advocate the Canadian Government to have a case manager assigned to veterans transitioning out of the CAF.***

[36] Exhibit – P-000290
[37] Transcript – June 22, 2021 – Pages 70, 71
[38] Transcript – June 22, 2021 – Page 71

While in treatment at the OSI Clinic under the care of Dr. Njoku and Dr. Murgatroyd, notes from Corporal Desmond's second therapy session with Dr. Murgatroyd described him as having continued "intrusive thoughts, disturbed sleep (including night sweats), paranoia and homicidal thoughts (without intent) …on [a] daily basis."[39] Corporal Desmond reported no suicidal thoughts.

When meeting with Dr. Murgatroyd during the second session which took place on July 3, 2015, Corporal Desmond stated he "needed a month off" and was going to Nova Scotia to "clear his head". Dr. Murgatroyd advised Corporal Desmond of concerns for his current mental health and lack of social supports. Corporal Desmond agreed to meet with Dr Murgatroyd on a weekly basis until such time as Corporal Desmond left for Nova Scotia. At that point, Corporal Desmond stated he intended to leave for Nova Scotia on July 16, 2015. As Corporal Desmond only had an appointment to see Dr. Njoku in late August, Dr. Murgatroyd arranged for Corporal Desmond to be placed on Dr. Njoku's cancellation list. Corporal Desmond was able to be provided an early appointment date of July 10, 2015.

On July 9, 2015, Corporal Desmond left a voicemail message for Dr. Murgatroyd cancelling his appointment for July 10, 2015, as he was leaving for Nova Scotia. Dr. Murgatroyd reached out later that day to speak with Corporal Desmond. Corporal Desmond indicated he would contact Dr. Murgatroyd when he returned from Nova Scotia.

[39] Exhibit – P-000244 – Page 79.

On his return from Nova Scotia, Corporal Desmond met with Dr. Njoku in August of 2015. Noting that Corporal Desmond was "still very severely suffering from PTSD symptoms." The doctor stressed the need for residential treatment.[40]

Corporal Desmond was also receiving treatment from Dr. Paul Smith between July 2015 and February 2016. Dr. Smith was a practitioner of family medicine and prescribed medical marijuana to Corporal Desmond. The utilization of medical marijuana with regard to the treatment of Corporal Desmond's mental health was an issue and appeared to lack efficiency. This was recognized apparently by Corporal Desmond himself who reported to Dr. Rahman that he had stopped using it as it did not agree with him.[41]

Difficulties continued with Corporal Desmond's ability to access treatment during the summer and into the fall of 2015. Corporal Desmond himself made calls seeking assignment of a case manager. [42] Corporal Desmond's lack of access to various programs was exacerbated in the summer and fall of 2015 by his unstable residency and difficulty establishing contact.

Corporal Desmond's case manager was assigned in November of 2015 and his first contact with her was on November 27, 2015. That same day, Shanna Desmond reported to police that she was receiving texts from Corporal Desmond that he was contemplating suicide. This resulted in RCMP members attending Corporal Desmond's residence in New Brunswick and taking him to the hospital.

[40] Exhibit – P-000244 – Page 34
[41] Transcript – February 4, 2020 – Page 83
[42] Exhibit – P-000273

On December 1, 2015, Corporal Desmond discussed with his case manager that he had been taken by the RCMP to the hospital as a result of being reported as suicidal by Shanna Desmond.[43] Corporal Desmond reported to his case manager that his wife had misinterpreted his words as he was simply saying goodbye over the phone. He denied being suicidal. The texts to his wife included instructions to tell his daughter that he will "see her in heaven" and that it was "time to go" and he would be "resting in peace." [44] The Inquiry heard repeatedly that the lack of accurate self reporting by Corporal Desmond appeared to cause issues in dealing with mental health providers. This is also important as it appears to set out his mindset regarding connecting his family to suicide.

There was difficulty with mental health providers having consistent interactions with Corporal Desmond. Dr. Njoku related that Corporal Desmond had been inconsistent with engagement with frequent moves back and forth to Nova Scotia.[45] Dr. Njoku recognized in his notes of December 3, 2015, that Corporal Desmond and his wife had frequent arguments. The doctor opined that it was "difficult to tell how much of this is purely their own relationship as against his hyper arousal from PTSD." In any event it is clear that the deteriorating domestic situation with the Corporal Desmond and his wife was affecting Corporal Desmond's mental health.

Dr. Njoku had noted on December 3, 2015, that there was an importance in Corporal Desmond having a clinical care manager which might offer him "a bit more support and motivation to re-engage with some structure." It should be noted that Corporal Desmond was not provided with a clinical care manager until a year later when

[43] Exhibit – P-000292 – Page 6
[44] Exhibit – P-000084
[45] Exhibit – P-000244 – Pages 31-32

he was assigned to Helen Luedee. He first met with Helen Luedee on November 30, 2016.[46]

Corporal Desmond also met with Dr. Murgatroyd on December 3, 2015. Corporal Desmond expressed a willingness to participate in the residential treatment program for OSI at Ste. Anne's Hospital in Montreal, Quebec. Dr. Murgatroyd also advised Corporal Desmond of the Operational Stress Injury Social Support (OSISS) Peer Support Program. Corporal Desmond was also able to sign a consent allowing New Brunswick Operational Stress Team (OST) to contact and share information with Shanna Desmond.

The recommendation for Ste. Anne's Hospital was officially made by Dr. Murgatroyd on December 15, 2015.[47] Corporal Desmond was able to have a session with both Dr. Murgatroyd and Dr. Njoku on separate times on January 4, 2016. Both Shanna Desmond and Aaliyah were in attendance. A subsequent appointment was scheduled for January 14, 2016, with Dr. Murgatroyd.

Dr. Murgatroyd proactively called Corporal Desmond's cellphone on January 19, 2016, and was able to speak to Corporal Desmond. A new appointment was made for January 22, 2016.

Corporal Desmond met with his case manager on January 16, 2016. At that time Case Manager Doucette completed the Area Counseller Client-Centred Assessment. That assessment showed Corporal Desmond struggled with a number of difficulties. They included poor mental health, backpain, feelings of isolation, poor memory, poor sleep,

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[46] Transcript – April 21, 2016 – Page 51
[47] Exhibit – P-000244 – Page 12

and no local support. He was aware of the OSISS program and was open to meeting with Peer Support but had yet to establish contact.

On January 17, 2016, VAC case manager Marie-Paule Doucette summarized the complexity of Corporal Desmond's transition to civilian life. Significant fragility and risk are identified with respect to Corporal Desmond's current circumstances. Ms. Doucette's case plan entry titled "**Overview of The Situation**" reads:

> a. Mr. Desmond is a 32-year-old CF veteran who was medically release d [*sic*] in 2015/07 as a result of a PTSD condition. He requested and was approved for VAC rehabilitation services as a result of barriers caused by said condition. In particular, the veteran reports great difficulties controlling his emotions and his generally heightened anxiety often leads to, or at least places him at ongoing risk of, anger outbursts or panic attacks. The veteran also reports difficulties in his marriage of 10 years (e.g. poor communication, conflict) and struggles with the instability of his living arrangements. [48]
>
> b. His home, in Oromocto NB, is for sale and any amount of time he spends there on his own causes him to feel lonely and to isolate given very limited local supports. He frequently travels between Oromocto and Antigonish NS, where his wife (and daughter) is residing and completing her nursing degree. [49]
>
> c. The veteran currently presents as lacking the ability to cope with his emotional turmoil and chronic back pain limits his ability to lead the physically active lifestyle he once had and desires. He values his immediate family and his roles as husband and father.[50]
>
> d. The veteran has proven he is open to receiving psychological help. The mental health professionals he has connected with report an inability to begin working through his military related trauma due to ongoing instability (i.e. "disabling symptoms of PTSD"). For now, he maintains regular contact with his mental health team with hopes of soon engaging in the stabilization and structured treatment they have formally recommended.[51]

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[48] Exhibit – P-000117 – page 1
[49] Ibid
[50] Exhibit – P-000117
[51] Ibid – Page 1

Consistently at the forefront of Corporal Desmond's list of priorities was having a happy and healthy relationship with his wife and daughter. Under the case plan heading of "**Where Do You Want to Be?**" Ms. Doucette notes:

> Within two years, the veteran wants to develop positive communication skills to improve his marital relationship, be a good role and present model for his daughter, and increase his abilities for future employment.[52]

During the January 26, 2016, assessment meeting, Ms. Doucette completed the Regina Risk Indicator Tool.[53] Corporal Desmond's score was now 22/65. This placed him at the "High Risk" category for an unsuccessful re-establishment into civilian life. "High Risk" is the highest risk level on the tool. It is notable in the seven-month period following his military release his risk level had risen. He scored 14/65 on May 25, 2015, one (1) month prior to his release from the CAF. At that time, he was in the "Moderate Risk" category. It should be expected that this change in risk would trigger an intensification of CAF to liaise with VAC to reduce the risk of poor reestablishment on Corporal Demond's release.

Ms. Doucette testified that when she administered the tool on January 26, 2016, she had the benefit of professional source information from New Brunswick OSI Psychologist Dr. Murgatroyd and Psychiatrist Dr. Njoku. Having such additional information added to the reliability of the results given that testing was then not totally based on Corporal Desmond's self-reporting.

In explaining what the January 26, 2016, score represents, Ms. Doucette testified:

> It's more about what, how right now at this moment based on the information he's reporting, how can we expect him to do, basically, or to succeed in rehabilitation.[54]

[52] Ibid
[53] Exhibit – P-000277

[54] Transcript – June 22, 2021 – Page 96

In notes prepared by Ms. Doucette after the January 3, 2017, tragedy she documented the following with respect to Corporal Desmond's marital situation during January of 2016:

> Veteran spoke of challenges in his marriage. He expressed struggles with living apart from his wife and daughter and spoke of how he looked forward to leaving Oromocto, a military town, behind. He described a [*sic*] conflictual relationships with his in-laws (wife's parents).[55]

Of immediate concern is the recognized need to structure/coordinate key resources which would have assisted Corporal Desmond in addressing his emotional instability both before and after attending the in-patient program at Ste. Anne's. This stability was never achieved. Ms. Doucette documented within the case plan the key "**Desired Outcome**."

> In three to six months, the veteran will learn and try new coping strategies to address the emotional difficulties – particularly those related to anger, sadness, and loneliness – that are causing a disconnect with his loved ones. The changes will be made, to the extent possible, through his active participation in mental health counselling and psychoeducation.
>
> …
>
> Despite participation in residential treatment (where both counselling and psychoeducation took place), the veteran does not appear to have effectively addressed his significant emotional difficulties. Work in this area is ongoing.[56]

As well, Ms. Doucette reviews the merits of the December 15, 2015, New Brunswick OSI referral for in-patient treatment at Ste. Anne's Hospital, Quebec. She consults a VAC Regional Mental Health Officer (RMHO) and the admissions nurse at Ste. Anne's Hospital. A portion of Ms. Doucette's progress note from this date reads:

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[55] Exhibit – P-000299 – Page 2
[56] Exhibit – P-000117 – Page 2

> Writer advised RMHO the referral came highly recommended by the veteran's team at the Fredericton OSI clinic in order to [*sic*] for him to stabilize emotionally and begin trauma related treatment in a structured environment. Writer has discussed the veteran's referral with the facility's Admissions Nurse. The RMHO indicated she reviewed, in preparation for this consult, a Psychiatric report on file as well as writer's recent AC assessment. She is of the opinion there is significant evidence in favour of in-patient treatment as a good starting point for psychosocial rehabilitation in this case.[57]

In the early stages of developing the case plan, the expectation was that once Corporal Desmond completed the in-patient program at Ste. Anne's, Quebec, he would continue engaging in regular follow-up with the already established New Brunswick OSI team. This team included Psychologist Dr. Murgatroyd and Psychiatrist Dr. Njoku. Unfortunately, this did not work out as planned. On January 26, 2015, a VAC Regional Mental Health Officer (RMHO) documented this expectation:

> CM states that psychologist has indicated that veteran is not yet stable enough to begin actual trauma work. Psychologist and psychiatrist recommend Ste Anne's stabilization program and have committed to continuing to follow veteran upon discharge.[58]

Further, at the Inquiry, Ms. Doucette testified to this original expectation:

> I mean it's probably wishful thinking, but it would have been helpful had he been able to continue at least for a short time with the team at OSI New Brunswick, who knew him and would have had a chance to see him post treatment, you know, have their own observations about any changes, that sort of stuff. But I understand the limitations of what can be done provincially but it certainly would have been helpful if the same providers could have stayed in place, yes, that would have made the work a lot easier for me, and I believe for him as well.[59]

[57] Ibid – Page 17
[58] Exhibit – P-000073 – Page 15
[59] Transcript – June 23, 2021 – Page 76

Revolving service providers and the lack of timely sharing of information/communication between health professionals is a recurring theme over the next year. It contributes to Corporal Desmond's spiraling instability.

Corporal Desmond attended his fourth psychiatry appointment on January 27, 2016. He then went on to miss two further OSI appointments on February 5, 2016, and February 15, 2016. Corporal Desmond advised he was in Nova Scotia and missed an appointment as he was confused because of the holiday. In Nova Scotia, a registered Provincial Holiday is set in early February. Corporal Desmond advised Dr. Murgatroyd that he had received a phone call from the intake nurse at Ste. Anne's Hospital. He was anticipating being admitted to Ste. Anne's Hospital in early March of 2016.

Corporal Desmond missed his seventh appointment in nine months with the New Brunswick OSI clinic.[60] Phone contact was made by Dr. Murgatroyd with Corporal Desmond on March 9, 2016. Corporal Desmond reported continued sobriety. It should be noted that Corporal Desmond in speaking with Dr. Smith appears to indicate he is still on a regime as prescribed for medical marijuana, while reporting to Dr. Murgatroyd that he is sober. Corporal Desmond was aware that he had to abstain from marijuana prior to admission to Ste. Anne's Hospital. Corporal Desmond's self reporting to medical practitioners appears to be inconsistent and hence problematic.

Dr. Murgatroyd on the same day contacted Ste. Anne's Hospital and spoke to the intake nurse, Teresa Rodriques who advised there were only ten beds for the nation-wide program with no spots available for Corporal Desmond at that time.

[60] Exhibit – P000244

In phone contact with Dr. Murgatroyd on March 23, 2016, Corporal Desmond advised his intake into Ste. Anne's Hospital was being delayed until May 2016. Corporal Desmond also advised that he is remaining in Nova Scotia. It was determined that follow up appointments will be by telephone.[61] That next phone appointment occurred on April 4, 2016.

On April 4, 2016, Corporal Desmond had a phone check up with Dr. Murgatroyd. Corporal Desmond indicated he would be seeking to delay his admission to Ste. Anne's Hospital until June. On April 5, 2016, Corporal Desmond in conversation with his case manager reported that while he had expected an admission date in late April, he would be delaying the same until sometime in June on his own accord.

Corporal Desmond's next OSI Clinic appointment was on April 25, 2016. In his session with Dr. Murgatroyd, Corporal Desmond learned his wife had called earlier wishing to speak to Dr. Njoku and Dr. Murgatroyd. This resulted in Corporal Desmond rescinding his consent for his doctors to communicate with his wife.[62] This inability to consult with Shanna Desmond caused Corporal Desmond's clinical team to be in a critical blind spot. Corporal Desmond described a deteriorating domestic situation that resulted in his relocating back to Oromocto, New Brunswick. Dr. Murgatroyd noted that Corporal Desmond needed to be seen more frequently in person.[63]

Corporal Desmond met jointly with Dr. Njoku and Dr. Murgatroyd on May 9, 2016. At that meeting Corporal Desmond disclosed he had called Ste. Anne's Hospital directly

[61] Exhibit – P-000244 – Page 55
[62] Exhibit – P-000244 – Page 17 and 25
[63] Exhibit – P-000244 – Page 52

to move his referral date forward. Dr. Njoku noted that Corporal Desmond could benefit from a clinical case worker. [64]

Corporal Desmond was scheduled to be seen at the OSI clinic on May 16, 2016. He failed to attend that appointment, making this the ninth missed OSI appointment. Corporal Desmond was able to reach out to Dr. Murgatroyd on May 19, 2016. He advised the doctor that he now had an admission date set for St. Anne's Hospital of May 30, 2016. Corporal Desmond was able to have a session with Dr. Murgatroyd on May 27, 2016, just days before leaving for Ste. Anne's.

Corporal Desmond's case manager, in efforts above what would be expected, accompanied Corporal Desmond on May 30, 2016, to the airport for departure for his inpatient treatment in Quebec.

Corporal Desmond was admitted to the OSI clinic on May 30, 2016. The next day an initial "Nursing Data Collection" and "Mental Status Exam" are completed. It is noteworthy that Corporal Desmond described a past suicide attempt four or five years prior.[65] This would have been between 2011 and 2012. There appeared to be nothing of this nature reported in the evidence before the Inquiry. Corporal Desmond was in the care of Dr. Joshi during this period. In February of 2013, Dr. Joshi reported that Corporal Desmond's symptoms were non-recurring regarding symptoms and that he be allowed to use weapons course in the field.[66]

[64] Exhibit – P-000244 – Page 28
[65] Exhibit – P-000254
[66] Exhibit – P-000222

The period that Corporal Desmond spends at the OSI clinic at Ste. Anne's Hospital is the most consistent and intense treatment that Corporal Desmond will receive. He was first placed in the stabilization department where treatment focused on sleep problems and daytime anxiety and depression.[67]

At Ste. Anne's, Corporal Desmond received care under Psychiatrist Dr. Robert Ouelette during the stabilization period, intake nursing staff, psychologist Dr. Isabelle Gagnon; Social Worker Kama Hamilton; Psycho-educator Marie -Eve Royer; Therapist Maria Riccardi.

During the residential phase, Corporal Desmond had 24/7 access to a full medical team comprising of the nursing staff, which include on call psychiatrists Dr. Ouellette and Dr. Dallal, physician Dr. Geneive Richer, Clinical Psychologist Dr. Isabelle Gagnon, two Social Workers, an Occupational Therapist, an additional counsellor and Psycho-educator, Marie-Eve Royer along with a Recreational Therapist and an Art Therapist.

It should be noted that while Dr. Oullette played a large role in the stabilization phase there was no contact with him after that. Dr. Oullette described how once a patient moves on to the residential stage he is treated by another doctor.[68]

Dr. Oullette testified that in June of 2016 Corporal Desmond became non-compliant in relation to the pharmacological treatment proposed by Dr. Oullette.[69] Dr. Oullette also agreed with Inquiry Counsel that Corporal Desmond's family situation was a compelling stressor.[70]

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[67] Exhibit – P-000254, Page 45
[68] Transcript – March 2, 2021 – Page 41
[69] Transcript – March 2, 2021 – Page 43
[70] Transcript – March 2, 2021 – Page 53

On July 4, 2016, Corporal Desmond transitioned from the stabilization unit at Ste. Anne's Hospital to the residential unit. Again, it is clear that in this phase Corporal Desmond had constant access to a psychiatrist, psychologist, nursing staff and various counsellors.

On August 9, 2016, a telephone conference is held between the clinical team at Ste. Anne's Hospital and Corporal Desmond's outside team, including his Case Manager Marie-Paule Doucette. Corporal Desmond made known his intentions to leave Ste. Anne's Hospital care early despite signs of destabilizations. His discharge date is August 15, 2023.[71] His early self discharge would clearly be against recommendation from his clinical therapeutic team.

During the case conference a recurring observation is made of the need for a neuropsychological assessment. The lack of such an assessment is highlighted throughout the clinical treatments dealing with Corporal Desmond. No such assessment was ever conducted. This report will deal with the question of neuropsychological assessments for Corporal Desmond later in this report.

At the case conference the Ste. Anne's Hospital team expressed several concerns to Corporal Desmond's case manager. These concerns were as follows:

1. Mr. Desmond is leaving program early;
2. Minor progress had been made in terms of stabilization and Treatment.
3. Cognitive limitations are identified and require a Comprehensive Neuropsychological Assessment.
    - The residency of Mr. Desmond once he is discharged is still uncertain. This given he intends to leave in less than a week.

[71] Exhibit – P-000244 – Page 45

- Mr. Desmond is in need of someone such as a clinical case manager to assist with facilitating contacts and appointments and managing his daily affairs.

The team at Ste. Anne's Hospital were to complete a report on Corporal Desmond's discharge and send to both the OSI team in New Brunswick and Corporal Desmond's case manager, Marie-Paule Doucette. This report was not forwarded until October 7, 2016. [72] There is no evidence that this was ever followed up by either Ms. Doucette or the OSI team in New Brunswick.

There was no arrangement made or attempted by any of those who were providing support regarding psychological counselling, marriage counselling, trauma intervention, social supports, a clinical care manager, medication monitoring as well as the neuropsychological testing mentioned above.

The greatest barrier regarding the availability and access by Corporal Desmond to appropriate Mental Health Services was the disconnect between Ste. Anne's Hospital and Corporal Desmond's arrival in Nova Scotia.

An appointment was arranged for Corporal Desmond with Dr. Murgatroyd for August 16, 2016. Corporal Desmond, however, relocated to Guysborough, Nova Scotia missing his appointment. This had a negative effect on the continued treatment plan with the OSI Clinic in New Brunswick.

Corporal Desmond came to Nova Scotia with no services or treatment plan in place. No arrangements had been made or explored for ongoing psychological counselling or other supports. Corporal Desmond's relationship with his wife was troubled and deteriorating.

[72] Exhibit – P-000244 – Page 45

While at Ste. Anne's Hospital Social Worker, Kama Hamilton had arranged a telephone call between Corporal Desmond and his wife. The purpose was to discuss Corporal Desmond's imminent discharge. Corporal Desmond appeared to be ambivalent regarding such a call but ultimately agreed. The call went poorly with a verbal exchange between the couple being filled with argument, interruptions, anger, shouting and swearing. [73] It ended with Shanna Desmond hanging up.

During the course of the telephone conversation Ms. Hamilton was concerned that Corporal Desmond was too volatile and angry and expressed that she feared he would be unable to regulate his moods. [74] Corporal Desmond begins to accept that he may not be welcome to live with his wife.[75] In spite of this deteriorated domestic situation Corporal Desmond chose to fly home to Nova Scotia.

[73] Exhibit – P-000254 – Page 266-267
[74] Ibid – Page 266 - 267
[75] Ibid – Page 266 - 267

Post Ste. Anne's Hospital

Case Manager, Marie-Paule Doucette was first documented as a specific individual to be Corporal Desmond's Case Manager (CM) on August 12, 2016. Social Worker, Helen Luedee of Sydney, Nova Scotia had agreed to act as a CCM for Corporal Desmond upon being certified to do so by VAC.

Helen Luedee has a master's degree in social work. She had been employed as a social worker since 2002. At the time of her testimony, she was a manager of Mental Health and Addictions Opiate Recovery Program Eastern Zone, Nova Scotia. In addition to her employment with various agencies and organizations, she has operated a private practice since 2012. In her private practice she has experience in working with both veterans and members of CAF.

In 2016, Ms. Luedee was put on an approved list of private service providers for VAC through Blue Cross. This was limited to providing counselling services. Until her involvement with Corporal Desmond in 2016, she had never been contracted by VAC to act in the capacity of a Veteran Clinical Care Manager.

Ms. Luedee testified her understanding of what she believed the role of a clinical care manager entailed:

> So, with being a clinical care manager, some of the things that I do is I help clients by identifying what are some of the needs of that client that are the wraparound supports that can help that person transition into success? How can I help that client navigate and identify resources of supports that will be helpful to them? I also directly work specifically with the case managers that would be involved.
>
> When we identify what some of the needs and goals are, I may have to then go to the case manager to see can we get some support? Can we make sure that there's funding that's involved? And if there's no funding through, for example, Veterans Affairs, is there other areas in the community where we can secure funding? We look at the actual community that is involved and

> what supports are available in that community. I would be responsible for creating with the client mutually-identified goals to work on, look at how we're going to accomplish that. So how do we measure those outcomes? I try to identify action plans to have step-by-step examples of how we will reach the goals. And, again, it's something that there is ongoing assessment where, again, we're going to be looking at building blocks, one issue at a time and one need at a time, to ensure that there's success for the client.

Ms. Luedee also testified to the unique barriers and lack of mental health resources in rural settings:

> Unfortunately, our rural settings are more challenged with not having the types of resources that are afforded to the bigger metropolitan areas, so it is challenging, yes. And when, as workers, we are used to working in rural settings with very limited resources, we have to become very skilled at being creative when it comes to looking for these resources, and the one benefit that I think we have is that many of us have networked and that's part of what we do for our profession, so we get to know some of the folks that are 8 doing various types of work and ... but it is challenging, yes.[76]

She went on to say:

> Sometimes, yes, because there's not ... just by the numbers, there's not an ... we don't have the numbers that they would in a bigger metropolitan area, so there's not a great big list to choose from. Not everybody has the skill-sets that are being sought after in rural settings. And just by distance alone, it takes more time to travel to areas and, yes, there can be barriers to successfully being able to connect with resources in rural settings.[77]

Corporal Desmond was able to meet with Helen Luedee for the first time on November 30, 2016, approximately three months after his return to Nova Scotia.

[76] Transcript – April 21, 2021 – Pages 23-24
[77] Ibid – Page 24- 25

Access to Mental Health Services in Nova Scotia on a General Basis

Mental Health Services in Nova Scotia can be accessed through the auspices of the NSHA, operated by the Province of Nova Scotia or through private Mental Health Care providers.

Examples of private Mental Health Care providers include Family Services of Eastern Nova Scotia (FSENS) primarily funded by the Department of Community Services, private health care counsellors such as Cathrine Chambers[78] and others.

The NSHA also operates the Nova Scotia Operational Stress Injury (OSI) Clinic. That clinic is a specialized care clinic available only to veterans and RCMP officers and is fully funded by the VAC. The clinic operates out of its Halifax, Nova Scotia location. VAC makes referrals to the Halifax OSI clinic and determines which individuals are approved for treatment. It is clear that a single location for the OSI clinic is problematic for those outside the Halifax Regional Municipality.

Additionally, the NSHA provides various mental health services in the following capacity:

1. Outpatient and Outreach services;
2. Community Mental Health supports;
3. Inpatient services, and;
4. Certain speciality services. Outpatient and Outreach Services that include mental health evaluation and crises intervention treatment in hospital emergency departments. The Inquiry also heard of these recent developments in relation to the Men's Helpline.

[78] Exhibit – P-000073

It is also encouraging that the Province of Nova Scotia's April 2023 announcement in of the creation of the Rapid Access and Stabilization Program for the Central Zone of Nova Scotia Health. The program aims to reduce wait times for community mental health services to provide short-term psychiatric care to patients earlier and to lessen the burden on hospital emergency departments. While this initiative is new and was not part of the original evidence before the Inquiry clearly it is relevant.

2. Recommendation: That the Rapid Access and Stabilization Program be funded by the Province of Nova Scotia to include all regions in Nova Scotia.

The Lack of a "warm handoff" from Ste. Anne's Hospital

The Inquiry heard concerns of a lack of a "warm handoff" for Corporal Desmond when transitioned from his care at Ste. Anne's Hospital to his therapeutic situation in Nova Scotia. A "warm handoff" is one where the transition or handoff is conducted in person, between members of the health care team, in front of the patient and, if possible, family. It includes the patient as a team member so that they can hear the discussion.

This lack of a "warm handoff" occurs to some extent from Corporal Desmond's instability of residence as well as his geographical location in a rural area of Nova Scotia.

While Ste. Anne's Hospital had prepared a discharge summary dated August 17, 2016, this summary was only provided to Dr. Murgatroyd at the New Brunswick OSI Clinic and Corporal Desmond's case manager. The report was faxed to the New Brunswick OSI Clinic on October 7, 2016.[79]

This report was never provided to Corporal Desmond nor to any health care professional in Nova Scotia. While it was provided to Corporal Desmond's case manager one has to wonder what prevented the clinic in Ste. Anne's from providing a digital copy to Corporal Desmond on discharge.

This question was also posed by Albert "Junior" MacLellan in his testimony before the Inquiry. Mr. MacLellan himself was a veteran and a family member of the victims. As he put it in his testimony:

> When, and why not only Department of National Defence, any government department releases a member with a psychiatric

[79] Exhibit – P-000244 – Page 85

> diagnosis of PTSD or otherwise what... to expedite him transferring from the internal medical system of DND to a provincial health authority why can't they give him a copy of his medical documents, CD form, or otherwise, on his way out the door? They've known for months you're getting medically releases.[80]

Had a discharge report, either digital or analog, been provided to Corporal Desmond, he then would have been able to give the same to health care providers in Nova Scotia. In turn those health care providers would have been in a position to have the report ingested into their own records.

3. *Recommendation: That the Nova Scotia Government liaise with the Federal agencies to ensure that those individuals diagnosed with PTSD or other health issues be provided in a timely manner a copy of their health records in the hands of Federal agencies to be ingested into Nova Scotia records*.

Corporal Desmond left Ste. Anne's Hospital on August 15, 2016. A little over a week later on August 24, 2016, Dr. Murgatroyd reached out by phone and spoke to Corporal Desmond. Dr. Murgatroyd noted that he was going to contact Corporal Desmond's case manger, Ms. Doucette, to explore community resources.[81]

On the same, date Ms. Doucette was in contact with Corporal Desmond and spoke to him about retaining Helen Luedee to act as his CCM. Corporal Desmond indicated he was ready to connect with Helen Luedee at any time.[82]

Having said the above, access by Corporal Desmond to his CCM, Ms. Luedee, was delayed as Ms. Luedee was required by VAC to register and complete Benefits and

[80] Transcript – February 17, 2021 – Page 41

[81] Exhibit – P-000244 – Page 43
[82] Transcript – June 22, 2021 – Page 229

Health Services OnLine (BHSOL) training. [83] The BHSOL system was a computer system for the documentation and filing of client records. Ms. Luedee testified that once it was available the training was fairly straight forward and only taking a couple of hours to complete.[84]

As of September 30, 2016, there had been no contact between Corporal Desmond and the New Brunswick OSI Clinic for one month. Dr. Murgatroyd, as indicated, faxed a referral on that date to the Halifax OSI Clinic. That referral was triaged by Nurse Nathasha Tofflemire. The Halifax OSI Clinic was in its infancy at that time. Nurse Tofflemire called Case Manager, Marie-Paule Doucette to discuss the referral.[85] Ms. Doucette advised that Corporal Desmond had decided to proceed with a community therapist as he resided in Antigonish. Nurse Tofflemire understood that Ms. Doucette would verify if Corporal Desmond had a family doctor before the referral proceeded. The file was placed on hold.[86]

Case Manager Doucette made no notes of this call but after the events on January 3, 2017, were made known to Ms. Doucette, she made an entry in her notes that Corporal Desmond had declined the services of the Halifax OSI Clinic due to geographical distance.

There was apparent confusion about whether a family doctor was a prerequisite or not for Corporal Desmond to be treated at the OSI Clinic. In any event Corporal Desmond decided not to use the Halifax OSI Clinic due to the geographical distance between Guysborough County and Halifax.

[83] Exhibit – P-000117 – Page 8
[84] Transcript – April 21, 2021 – Page 34-37
[85] Exhibit – P-000147 – Page 2
[86] Ibid – Page 2

Corporal Desmond's residency in a rural setting is one element that frustrated his access to appropriate mental health services including OSI treatment. This difficulty was explored in testimony before the Inquiry.

An example is part of the testimony provided by Case Manager Ms. Doucette's interaction with Inquiry counsel. Ms. Doucette testified as follows regarding the option of the Halifax OSI Clinic:

> So I talked to him about that and he was still not interested. And so the last piece I explored with him was, Well, what about psychiatry services because he, you know, had some things prescribed to him at Ste. Anne's and was probably going to need the oversight of a psychiatrist for medication management. That stuff. I suggested that maybe it would be easier if he connected with a psychiatrist at OSI, and then if he wanted to work with a different provider for actual therapy, then that was a possibility too.
>
> So we had that conversation. He decided that he wanted to work with professionals in his community. This is something that I clearly remember discussing with him. In reviewing my notes post-tragedy, I realized that it wasn't documented, (a) because I was on the road and (b) because he decided not to go ahead with it. I don't know if, at the time, I thought, well, move on to the next thing, but it was documented after the fact in a different report.

Ms. Doucette was aware that a treating psychiatrist was essential to Corporal Desmond's rehabilitation. Curiously, once he elects to pursue this resource in his community rather than at the Nova Scotia OSI Clinic in Halifax the discussion seems to end. Ms. Doucette never attempted to assist in coordinating this resource near his rural community. She never followed up with him to determine whether or not he had any success in finding a psychiatrist. [87]

In cross examination by Mr. Russell, Ms. Doucette indicated as follows:

Q. … did you ever once ask him, did you ever find a

[87] Transcript – June 23, 2021 – page 124

psychiatrist?

A. I don't remember. I have instructed him to always let me know when there's a change so that we can be on top of that, but if I asked that question specifically, I don't recall.

Q. And it's fair to say, if you asked that question in the fall of 2016, you would've learned about the existence of Dr. Slayter?

A. Potentially, yes.

Q. And if you knew about the existence of Dr. Slayter, I guess it's fair to say you would've became engaged to the extent of maybe suggesting to Lionel Desmond somehow that Dr. Slayter could start to liaise with Helen Boone, Cathrine Chambers. Is that something you would've done?

A. Yeah, well which was the point of having a CCM involved was that if there is a need for the psychologist and the psychiatrist to be connecting, then we can facilitate that.

In further cross examination by Shane Russell the following conversation is held:

MR. RUSSELL: Is it possible that you, at times, might've overestimated Lionel Desmond's ability to make those contacts and resources, such as when it came to psychiatry?

A. It's possible.

Q. ... is it possible that you might have overestimated his ability to find a psychiatrist in his community in Nova Scotia and to be diligent in following up with that psychiatrist?

A. It's possible, yes. He gave me the impression at that... during that conversation that he was capable and that he was going to go look for that. And if I didn't do follow up in due time, I take responsibility ...[88]

Furthermore, Ms. Doucette was given an opportunity to review Nova Scotia OSI Nurse Natasha Tofflemire's note from October 6, 2016. She was asked to

[88] Transcript – June 23, 2021 – Page 132

comment on two (2) things:

> 1) Ms. Tofflemire's documented suggestion that Ms. Doucette was going to verify whether Lionel Desmond had a family doctor before proceeding with the Nova Scotia OSI referral for psychiatry;
>
> 2) Whether Ms. Doucette was told or given the impression from the Nova Scotia OSI Clinic that having a family doctor was a prerequisite or preferred requirement before accessing Nova Scotia OSI's psychiatry service.

Ms. Doucette testified:

> **A.** I don't remember that specific detail. I think as I mentioned before, potentially because if that was necessary for a referral, I didn't consider it a huge hurdle that they would try to figure out if there was a physician in the local community. What I'm . . . I'm not questioning the note. I'm questioning the time that the note went in because, obviously, the conversation that I had with Mr. Desmond about psychiatry, which I had hoped that he would go to OSI for psychiatry, he turned down that option.[89]
>
> **Q.** And do you remember having any sort of discussion with her about him needing or preferred that he have a family physician before he is able to access that service in Nova Scotia, OSI?
>
> **A.** I don't recall. I don't recall that specific detail. However, it is quite possible that we discussed that ...
>
> **Q.** Do you recall any sort of discussion about him and a family doctor? Do you recall ever bringing that up to him?
>
> **A.** Not specifically, no.[90]
>
> **A.** So was I telling her at that time, okay, he already told me that he would prefer a therapist in the community but we will seek to get the services of a psychiatrist. Then I follow up with Mr. Desmond. He tells me, No, I don't want to go there for psychiatry. And then I am pretty confident that I called back but, like I said yesterday, I may have left a voicemail message letting her know that we weren't proceeding with a referral at that time.[91]

Finally, during her Inquiry evidence Ms. Doucette was given an opportunity to review the October 18, 2016, entry from New Brunswick OSI Psychologist Dr.

[89] Transcript – June 23, 2021 – Page 208
[90] Ibid – Page 208- 209
[91] Ibid – Page 210

Murgatroyd. On that date Corporal Desmond advised Dr. Murgatroyd that "he is in the process of being assigned a family doctor."[92]

Ms. Doucette testified:

> **Q.** To your knowledge, do you know of anyone that said to Lionel Desmond that he was going to be assigned or have arranged for him a family doctor?
>
> **A.** No, I would only know that from him, if he provided me that information.

Corporal Desmond's first local contact with health providers after his discharge from Ste. Anne's Hospital occurred on October 13, 2016, when he attended the Guysborough Medical Clinic along with his wife Shanna.[93]

At the Guysborough Clinic, Corporal Desmond met with Dr. Luke Harnish. Dr. Harnish is an emergency medicine doctor who at that time was doing a locum at the medical clinic. October 13, 2016, would have been the only interaction Dr. Harnish had with Corporal Desmond. According to Dr. Harnish, Corporal Desmond was inquiring about a follow-up plan for Nova Scotia after discharge from Ste. Anne's Hospital. Corporal Desmond had no idea what that plan might be and did not know where else to turn.[94]

Corporal Desmond had no charts or reports from Ste. Anne's Hospital nor any other past medical documentation, save and except those records from the clinic itself. Dr. Harnish was only able to determine Corporal Desmond's medication regime as Corporal Desmond brought his medication in a shopping bag. Dr. Harnish, with the

[92] Exhibit P-000244 – Page 42
[93] Transcript March 10, 2021 – Page 137

[94] Transcript – March 10, 2021 – Page 137

help of the Desmond's, did an internet search, however, to find any information regarding the OSI Clinic at Ste. Anne's Hospital.

The visit ended with the plan, given the circumstances, Corporal Desmond would obtain records from Ste. Anne's Hospital and NBOSI and continue as a patient at the clinic. In the event of a crisis, Corporal Desmond agreed to either come back to the clinic or the emergency department. [95]

During this period, Helen Luedee continued to be frustrated in her efforts to get the required BHSOL training in order to commence work as Corporal Desmond's CCM. This continues until the later part of November 2016. At that point Case Manager Doucette and Ms. Luedee decided to "go ahead and just do this."[96] The actual training required by VAC for Ms. Luedee did not take place until January 23, 2017, three weeks after the tragedy.

On the October 18, 2016, Corporal Desmond was contacted by Dr. Murgatroyd, one of the most proactive clinicians involved with Corporal Desmond, who was advised by Corporal Desmond that he was in the process of being assigned a family doctor, that he has been in touch with the Halifax OSI Clinic, that he would access local resources regarding his OIS due to travel and that he had no local therapist.

On October 24, 2016, Corporal Desmond once again attended a local medical facility when he appeared at the outpatient department of St. Martha's Regional Hospital. He is seen by nurse Heather Wheaton and Dr. Ian Slayter. [97] Dr. Slayter is a general adult psychiatrist.

[95] Ibid – Page 147-151
[96] Transcript – April 21, 2021 – Page 44
[97] Exhibit – P-000067 – Page 7–10

Corporal Desmond arrived with his wife Shanna in what was described as a "situational crisis." A Crisis Response Service Mental Health Risk Assessment was completed by Nurse Wheaton.

Dr. Slayter saw Corporal Desmond for about thirty minutes. The doctor assessed Corporal Desmond's suicide risk as low. In addition to other medications Corporal Desmond was already prescribed, Dr. Slayter added Trazodone. The doctor also advised Corporal Desmond that he needed services and that if they did not start quickly Dr. Slayter would be happy to see him until OSI picked him up. Dr. Slayter described Corporal Desmond as falling through the cracks regarding VAC follow-up.

Corporal Desmond made a further appointment with the Guysborough Medical Clinic on November 1, 2016. He made the appointment due to his ongoing PTSD symptoms and on this date was seen by Dr. Ranjini Mahendrarajah. She was told by Corporal Desmond that he had been seen by Dr. Slayter, and since Corporal Desmond did not seem to be in acute distress, the doctor made another referral to be seen again by Dr. Slayter.[98]

On November 7, 2016, Case Manager Doucette contacted Cathrine Chambers, a registered counselling therapist located in Antigonish, Nova Scotia. The purpose was to arrange local counselling for Corporal Desmond. Ms. Chambers recalled in her testimony that Ms. Doucette was awaiting a signed consent from Corporal Desmond allowing details of his treatment to be discussed.

[98] Exhibit – P-000092; Transcript – March 9, 2021 – Pages 44-58

On a second call Ms. Doucette gave further background information to Ms. Chambers regarding Corporal Desmond.[99] Ms. Chambers was not provided past medical records from VAC, nor did she request them.[100]

Ms. Doucette, in her notes, refers to Ms. Chambers as a psychologist, a qualification Ms. Chambers lacked.[101] The indications were also that Ms. Doucette would send proper contact forms to Ms. Chambers for Corporal Desmond to sign. These required forms were never sent and, despite having Ste. Anne's Hospital discharge summary in her possession, it was never forwarded to Ms. Chambers. Obviously, such a release would be dependent on obtaining Corporal Desmond's consent, which could not come until he signed the proper forms.

The following material documents were in the possession of VAC and not shared with Therapist Cathrine Chambers.

1. May 25, 2015, CAF Transition interview Report (8 pages)
2. August 17, 2016, Ste. Anne's Interdisciplinary Discharge Summary (8 pages)
3. December 15, 2015, Ste. Anne's referral from New Brunswick OSI with supporting psychiatry report from Dr. Anthony Njoku
4. Case Plan documents and Case Plan reports
5. January 5, 2016, Area Counsellor Client-Centred Assessment (10 pages)
6. Various CAF nursing reports in the possession of VAC.

[99] Transcript –February 12, 2020 – Pages 142-144
[100] Ibid
[101] Exhibit – P-000117 – Page 7

At the Inquiry Ms. Doucette was asked about the possibility of sharing such records with Therapist Cathrine Chambers. Ms. Doucette testified:

> **Q.** In terms of Mr. Desmond and Ms. Chambers starting that relationship, did you provide any documents to Ms. Chambers?
>
> **A.** No, not right off the bat. I recall a conversation where I sort of, you know, asked how she wishes to proceed with new clients. It's really not a case manager's place to tell a professional how to run their practice and I remember . . . a detail that I remember speaking to her. Now I don't know if that was the first time we spoke or in a follow-up saying to her that we had recent assessments completed on file so if that was ever helpful to her, then she can definitely request and obtain the veteran's consent for some of that information to be shared. So, there was never sort of any withholding of information, but we don't just freely share things without the veteran's consent. So, I believe in the end what happened was that she decided to meet the veteran and do her own sort of form of assessment and then would return with questions if there were any.[102]

More generally, Ms. Doucette further testified as to her understanding of a veteran's medical records within the VAC structure:

> a. So I don't consider or understand VAC to be sort of a keeper of medical information. Like it's not a place where everything gets turned over. Some medical information or psychological information will come to us by way of program participation or, like in the rehab programs, for example, which is what I'm most familiar with, we will have summary reports, recommendations from professionals. That sort of stuff. And that goes on their file but it's not
> . . . like, one, it's not information that belongs to me as a case manager or a VAC employee. It's really evidence on the veteran's file.
>
> b. And they're aware of that generally, that if they ever want to access something on their file, that there's a process that they can go through to obtain that. And it's happened before. I've had some veterans request some aspects of their file.
>
> But yeah. Not a keeper of medical records by any means.[103]

[102] Transcript – June 22, 2021 – Pages 185-186
[103] Transcript – June 22, 2021– Pages 204-205

On December 2, 2016, Corporal Desmond attended a two-hour appointment with Dr. Slayter at St. Martha's Regional Hospital. Dr. Slayter diagnosed Corporal Desmond with the following:

- Major Depression
- Post-Traumatic Stress Disorder (PTSD)
- Post-Traumatic Brain Disorder
- Borderline Delusion re: wife
- R/O Attention Deficit Disorder (ADD)
- Suicide Risk - Low[104]

Corporal Desmond attended for his first appointment with Cathrine Chambers on December 2, 2016, after seeing Dr. Slayter. It was anticipated that her treatment would begin with an assessment phase of between three to six sessions.[105] During the first session Ms. Chambers agreed with Corporal Desmond that there would be at least six sessions for the assessment phase given his complexity. Surprisingly, Corporal Desmond did not apprise Ms. Chambers that he had an earlier session with Dr. Slayter. Important historical documentation regarding Corporal Desmond's PTSD and long-standing domestic issues were not provided to Ms. Chambers.

In what is a recurring theme, Dr. Slayter was advised by Corporal Desmond of falls he had resulting in head injuries while serving in the CAF. Suspecting Corporal Desmond may have suffered a concussion, Dr. Slayter identified the need for a neurocognitive assessment. Dr. Slayter further observed that Corporal Desmond needed an intensive treatment program and advised Corporal Desmond to contact the OSI Clinic in Halifax. Dr Slayter also asked Corporal Desmond to obtain his military medical records. This again shows the need for seamless following of medical records

[104] Exhibit – P-000067 – Page 27
[105] Transcript – February 12, 2020 – Pages 127-128

of medically discharged CAF personnel to their province of residence. Corporal Desmond had a follow-up scheduled in two to four weeks.

On December 9, 2016, Corporal Desmond was scheduled to meet with Therapist Chambers who wanted to see him weekly. He missed this appointment but did make his second appointment with Helen Luedee scheduled for that day. Ms. Luedee obtained a consent form for Corporal Desmond to share information with FSENS with the understanding that a referral to that service would be beneficial regarding couples counselling and services through the Men's Health Centre in Antigonish.

In addition, Corporal Desmond readily agreed to sign a second consent to release information. This second consent was sent by VAC to Helen Luedee. The consent form was drafted by VAC and authorized them to collect information from third parties about Corporal Desmond, to support the administration of VAC benefits or services.

Interestingly, this is a one-way flow of authorized sharing of information. VAC has requested that Corporal Desmond sign a consent allowing Ms. Luedee to share her information with them, however; there was no such consent flowing the other way. VAC never sent Ms. Luedee a consent for Corporal Desmond to sign which would have allowed them to share with Ms. Luedee documents and information they had in their possession. Similar to Therapist Cathrine Chambers, Ms. Luedee never had access to critical information contained within the following documents:

a. May 25, 2015, CAF Transition Interview Report (8 pages)

b. August 17, 2016, Ste. Anne's Interdisciplinary Discharge Summary (8 pages)

c. December 15, 2015, Ste. Anne's referral from New Brunswick OSI with supporting psychiatry report from Dr. Anthony Njoku

d. Case Plan documents and Case Plan reports

e. January 5, 2016, Area Counsellor Client-Centred Assessment (10 pages)

f. Various CAF nursing reports in the possession of VAC.

Ms. Luedee did not receive medical records, summaries, or particulars surrounding Corporal Desmond's symptoms, treatments, stressors, and psychosocial history prior to her being retained.

Over the course of her two meetings with Corporal Desmond, Ms. Luedee identified many interventions which need to be given immediate priority. Ms. Luedee documented these in her CCM - Outcomes Agreement. The "**Mutually Identified Needs**" include:

1. "Ongoing needs assessment"
2. "Daily/weekly telephone contact"
3. "Expand social network"
4. "Other - specify OT Assessment"
5. "Plan for activities of daily living"
6. "Housing or vocational support"
7. "Practical assistance"
8. "Other - specify couples counselling"

Ms. Luedee proceeds to identify what she views as "**Desired outcome No. 1**." This top priority is noted as:

> Assist veteran with re-engagement with family and also establishing new and healthy routines in his new home.

Finally, the action steps listed by Ms. Luedee to achieve this desired outcome include:

1. find resources in new community to help establish new routines for daily living
2. contact referral source (Men's health centre/Family Services)
3. contact private counsellors regarding possibility for couples counselling
4. go to FSENS (and Men's Health Centre) regarding previous referral

Ms. Luedee testified as to what she meant by "Plan for activities of daily living" and "Practical assistance." The first includes ways Corporal Desmond could make healthy connections with his family and daughter on a regular basis. The second includes strategies to prevent Corporal Desmond from getting overwhelmed. It also includes a way of reducing barriers in "navigating the system." It would involve making phone calls and providing him with information in advance.[106]

On that same date of November 9, 2016, Corporal Desmond contacted FSENS by phone for couples counselling with his wife. He was provided an intake date of January 16, 2017, with a Social Worker.

Corporal Desmond spoke about this with Helen Luedee on December 12, 2016. He indicated he wished to engage in private couples therapy as opposed to through FSENS as his wife apparently expressed concerns that she may have interaction with her co-workers. [107]

Corporal Desmond attended his second session with Therapist Chambers on December 15, 2016. It would be his last.

[106] Transcript – April 21, 2021 – Page 95
[107] Exhibit – P-000283-Page 2

Ms. Chambers had difficulty drawing information from Corporal Desmond. As well, she had no knowledge of the extensive therapeutic background reports that existed. Ms. Chambers conducted an Individual Psychotherapy Assessment form.[108] Part of her plan during the assessment phase of the initial six sessions was to conduct a risk assessment covering suicidal risk, homicidal risk, self harm, and substance abuse.

Ms. Chambers also noted that, during her very brief interactions with Corporal Desmond, she determined that Corporal Desmond had frequent suicidal ideation such as "I wish I'd blown up in Afghanistan."

Further Ms. Chambers reported a lack of knowledge regarding Corporal Desmond's diagnosis and history. Had she known the full extent of Corporal Desmond's complex psychological profile and his clinical instability she would have determined that her expertise was not suitable in that situation and that Corporal Desmond would not have been a good candidate for community-based psychotherapy but rather required inpatient care.[109]

Corporal Desmond had further contact with the Guysborough Medical Clinic on December 19 and 20, 2016. He had previously had a cut to his hand from drying dishes. He attended on December 19, 2016, to have his dressing changed and made an appointment for a prescription refill the next day. On December 20, 2016, he saw Dr. Khakpour and described continuing PTSD symptoms. Dr. Khakpour did not believe Corporal Desmond was suicidal at the time and the Corporal had an appointment to

[108] Exhibit - P-000076 – Pages 1 - 3
[109] Transcript – February 13, 2020 – Page 141

see Dr. Slayter the next day on December 21, 2016. Corporal Desmond failed to attend for his appointment with Dr. Slayter.

Corporal Desmond's further interaction with medical personnel in early January leading up to the tragedy are related previously in this report outlining the circumstances of his release from St. Martha's Regional Hospital on January 2, 2017.

Conclusionary comments regarding whether Corporal Desmond had access to appropriate Mental Health Services

The disconnect between VAC retaining clinical assistance for Corporal Desmond in a timely manner and the provisions of mental health records to provincial health providers resulted in a large crack in psychotherapy through which Corporal Desmond fell.

This was referred to by the Attorney General of Canada in the written submissions of counsel as "a series of logistical misfortunes admittedly hampering Ms. Doucette's efforts to bring Ms. Luedee up to date."

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

Current status of the NS OSI Clinic:

As noted, in late 2016, Corporal Desmond did not avail himself of the services of the nascent Operational Stress Injury (OSI) Clinic. The inquiry heard evidence from administrators and clinicians at the OSI Clinic regarding its present structure and the services it provides. The Inquiry heard that the NS OSI Clinic has grown and evolved since

2016 and is now able to provide more services than at the time of Corporal Desmond's brief interaction with staff at the clinic.

The Inquiry heard from both Dr. Abraham Rudnick, Clinical Director of the NS OSI Clinic and Patrick Daigle, the Provincial Health Services Manager for the Clinic who employ a co-leadership model. Dr. Rudnick described the various treatment modalities and services provided (as of March 2021) at the NS OSI Clinic. As of December 2020, the Clinic had 206 active clients.[110] While Dr. Rudnick explained that many of the Clinic's clients suffer from co-morbidities, fifty percent (50%) of the clients have PTSD as their primary disorder.[111]

Mr. Daigle described the expansion of the Clinic from the time he became Health Services Manager in February 2018 to March 2021. This staff now includes six full-time social workers (four in Dartmouth and two in Cape Breton), three psychologists (with a plan to add a fourth at the time of his testimony), one nurse practitioner, two occupational therapists, three nurses, a family physician, and an additional psychiatrist.[112]

Some of the issues faced by clinicians who dealt with Lionel Desmond were addressed by Dr. Rudnick and Mr. Daigle. For example, they said that accessing a patient's earlier medical records for the Clinic can still be challenging sometimes. Whether clients arrive with records if they have received treatment elsewhere was described as "hit or miss." [113] Mr. Daigle emphasized the importance of obtaining as much information as possible about the client's treatment at the intake stage but could not say precisely how many clients come to the Clinic with what might be described as a complete

[110] Transcript – March 11, 2021 – Page 16
[111] Ibid – Page 19
[112] Ibid – Pages 39, 176-177, 190

[113] Ibid – Page 64

package. He gave a rough estimate of sixty percent.[114] The Clinic does have access to the NSHA databases including MEDITECH and OneContent.[115]

The previous practice of requiring a client to have a family physician prior to seeing a psychiatrist no longer exists.[116] Both Dr. Rudnick and Mr. Daigle spoke about the increased use of virtual health with clients. Mr. Daigle explained that the primary treatments for PTSD – prolonged exposure, cognitive processing therapy and EMDR – can be done virtually. [117] A hybrid model of in-person and online treatment will continue post-Pandemic.[118]

Neuro-psychological assessments*:*

One consistent recommendation that recurs in the reports and treatment plans of many of Corporal Desmond's treating professionals was the need for a neuropsychological assessment. He was never given one, despite numerous clinicians expressing the opinion that it would be beneficial in assessing any cognitive deficits. Witnesses at the Inquiry expressed different opinions regarding the availability and wait times for such an assessment in Nova Scotia.

4. Recommendation: NSHA/NS Department of Health and Wellness assess the availability of neuropsychological assessments in the province and, if needed, take steps to ensure they are more readily available.

Assessment of suicide risk by mental health clinicians:

[114] Transcript – March 11, 2021 – Page 204
[115] Ibid – Page 65
[116] Ibid – Page 224
[117] Ibid – Pages 48-51, 238
[118] Ibid – Page 52

The Inquiry heard evidence about the manner in which mental health clinicians assess suicide risk. The NSHA Mental Health & Addictions Policy and Procedure, *Suicide Risk Assessment, Intervention (SRAI), Monitoring and Management for Mental Health and Addictions*, was made an exhibit at the Inquiry.[119] That Policy contains a suicide risk assessment and intervention tool. Dr. Rahman described the implementation of this instrument and the training of staff on it. [120]

Other suicide risk assessment tools and instruments are used. Dr. Slayter and Mental Health Nurse Heather Wheaton completed and referred to an earlier version of this tool which was embedded in the Crisis Response Service Mental Health Risk Assessment document.[121] Nancy MacDonald testified that FSENS utilizes a suicide risk assessment tool which is based on other evidence-based risk assessment tools.[122]

Dr. Scott Theriault testified that while it is impossible to predict "whether any individual at a point in time will commit suicide," suicide risk assessment tools assist in creating risk management plans. This allows for a "safety net" that could be utilized when individuals go through periods of acute crises where their suicide risk may be elevated.

There appears to be value in the use of an evidence-based suicide risk assessment tool for mental health clinicians. On-going training in this area for staff engaged in mental health is also essential.

5. Recommendation: The NSHA continue to update its SRAI suicide risk assessment policy and tool based on the most up-to-date evidence on suicide risk assessment and continue to train staff engaged in

[119] Exhibit – P-00105
[120] Transcript – February 4, 2020 – Pages 161-162
[121] Exhibit – P-000067 – Pages 15017
[122] Exhibit – P-000314

mental health on the SRAI policy and tool and be provided adequate funding by the Province of Nova Scotia.

FSENS Men's Health Centre/Men's Helpline:

On January 3, 2017, Corporal Desmond contacted FSENS to change an upcoming appointment from couples counselling to individual counselling.[123] He had originally been encouraged to contact FSENS by his CCM. Obviously, Corporal Desmond was never able to attend this appointment. However, the Inquiry heard about the work done at FSENS in general and through its Men's Health Centre and its navigator position.[124] At the time of her testimony, Ms. MacDonald indicated that funding for the navigator position had ended.

Ms. MacDonald also described the new 24-hour Men's Helpline operated by FSENS, which is available through the Provincial 211 system, and which launched in September of 2020. Ms. MacDonald described the system as a free confidential service for men who are experiencing concerns about their well-being or are under stress (although it is not a crisis line). The caller will reach an individual who will assist them in navigating referrals and provide brief intervention counselling. [125]

Were this service to have been available to Corporal Desmond, it could have provided an opportunity for further engagement and assistance in navigating access points for his continued treatment.

[123] Transcript – September 15, 2021 – Page 146
[124] Ibid – Page 59
[125] Transcript – September 25, 2021 – Pages 71-106

Mental Health Services for the African Nova Scotian Community:

One issue explored by the Inquiry was focused on the unique needs of the African Nova Scotian community as they navigate the health care system and seek mental health care services. The Inquiry heard from four witnesses who testified under the umbrella of the Health Association of African Canadians (HAAC). The Inquiry heard that there is a "lack of culturally specific mental health and intimate partner violence services in Nova Scotia" and that there is an "inability to access informed and culturally specific health resources and culturally competent care." [126] They pointed to an overall mistrust of the healthcare system in the Black community.

In 2017 and 2018, HAAC contracted with Lana M. MacLean & Associates to conduct psychoeducational sessions to underserviced African Nova Scotian communities with a particular focus on rural communities such as Sunnyville, Lincolnville and Upper Big Tracadie. What members of these communities described was "the lack of community navigation into the conventional mental health and addictions programs, the lack of accessibility to treatment programs (transportation and time) and [the] lack of mental health and addiction literacy in the community.[127]"

It is difficult to know what may have been different if Corporal Desmond had had access to more culturally relevant mental health care services and if he had more opportunity to see and interact with health care providers who were of African descent. That said, there is certainly room to continue to work to ameliorate the current situation where African Canadian and other racialized consumers of mental health services struggle

[126] Exhibit P-000347 – Page 1
[127] Ibid – Page 3

to find culturally relevant services. The HAAC brief[128] makes recommendations in this regard.

6. Recommendation: The Nova Scotia Department of Health and Wellness (DHW)/Nova Scotia Health Authority (NSHA) partner with appropriate community organizations to provide more comprehensive virtual care to rural African Nova Scotian communities.

7. Recommendation: The NS DHW / NSHA take steps to recruit Black and diverse mental health providers to provide culturally informed and responsive care with an emphasis on training in the areas of psychosocial services, occupational stress, and general mental health and addictions with appropriate Provincial funding.

8. Recommendation: The NS DHW / NSHA should recruit and provide educational scholarships for Black registered nurses and nurse practitioners with appropriate Provincial funding.

9. Recommendation: The Network of Black mental health providers built from the work of the NS Mental Health and Addiction Strategy should be supported and adequately resourced by the Province of Nova Scotia.

[128] Exhibit – P-000347 – Pages 10-11

PART V

Whether Lionel Desmond and his family had access to appropriate Intimate Partner Violence intervention services

Whether Lionel Desmond and his family had access to appropriate Intimate Partner Violence intervention services

The evidence in this Inquiry presented a picture of mental health issues such as PTSD and intimate partner violence as being very often a tightly woven fabric of those two threads. There is an impression that often clinicians assumed Corporal Desmond's mental health issues and the existence of domestic upheaval would be dealt with by treating his PTSD and depression and the Intimate Partner Violence concerns would follow. The evidence suggests, however, that the comorbidity of mental health and intimate partner violence are such that neither can be assumed to be resolved by treatment of the other.

While those mental health clinicians who treated Corporal Desmond understood his PTSD diagnosis, they did not always see or understand that his domestic life was deteriorating to a dangerous extent. The overview presented to this Inquiry showed Corporal Desmond had an increasing suspicion of, and, at times, resentment towards his wife. His struggles with his symptoms coexisted with his life's lack of direction on exiting the CAF.

At the same time his wife was embarking on a demanding career as a Registered Nurse. With Corporal Desmond's mood swings, outbursts and other problematic behaviours, Shanna clearly was edging towards terminating their relationship. This was counter to Corporal Desmond's ongoing wish to keep his family together.

Corporal Desmond, for his part, lacked clarity in his thought process resulting in deep suspicions of his wife's fidelity that were overly valued and baseless. At times Corporal Desmond understood this, but often he did not. It is clear that throughout

Corporal Desmond's transition from CAF to VAC and his relocation to Guysborough County, he had a focus on maintaining his relationship with his wife despite the trials and tribulations that it brought him and his family. Surprisingly, the Discharge Summary is devoid of any references to marriage counselling or intimate partner violence intervention.[129]

In Corporal Desmond's first meeting with Helen Luedee on November 30, 2016, relationship counselling and "Men's Health Issues" and resources were identified as immediate community care.[130]

As well, Therapist Cathrine Chambers identified that it would have been important for her to have known that Corporal Desmond had long standing jealousy directed towards Shanna, coupled with his dreams of harming her. Had Ms. Chambers known she would have given counselling towards intimate partner violence a priority at the outset. [131]

Helen Luedee testified that at her second meeting with Corporal Desmond, they agreed to a referral to FSENS. Corporal Desmond signed a consent to share information with FSENS.[132]

The Inquiry heard from Stephanie MacInnis-Langley regarding services available for families dealing with intimate partner violence. Ms. MacInnis-Langley is the Executive Director of the Nova Scotia Advisory Council on the Status of Women.

[129] Exhibit – P-000254 – Page 274
[130] Exhibit – P-000288 – and Transcript April 21, 2021 – Page 57
[131] Transcript – February 13, 2020 – Pages 83-85
[132] Exhibit – P-000283

She provided the Inquiry with a broad but comprehensive overview of those services regarding intimate partner violence intervention available in the geographical area of Guysborough and Antigonish County, as well as the province as a whole.

Ms. MacInnis-Langley described multiple services in Nova Scotia including 1-800 lines and websites. The 1-800 number is available for anyone calling for support or services in the area of intimate partner violence. A further 1-800 number was developed in 2020 specifically for men. Not unlike the 911 number with which most of us are familiar with, there is a 211 number which connects the caller to any number of services including those dealing with intimate partner violence. One connection through 211 would be to a Men's Helpline. In its first year the Men's Helpline had 800 calls.[133]

Further evidence was provided regarding the existence of transition homes for women who are subjected to intimate partner abuse.[134] Also, there are nine women's centres across Nova Scotia. These are drop-in centres that operate during business hours and provide program counselling and advice on existing services.[135]

Not all of the services outlined by Ms. MacInnis-Langley were available to individuals, including the Desmond family, in the period leading up to the January 3, 2017, tragedy. In 2018 the Province of Nova Scotia implemented an action plan on violence against women called "Standing Together."[136] This served to co-ordinate government and community response to intimate partner violence.

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[133] Transcript – September 14, 2021 – Page 13
[134] Ibid – Page 19
[135] Ibid – Page 21
[136] Ibid – Page 13

As of the writing of this report the Standing Together program has a robust website at https://novascotia.ca/standingtogether. Through this site, one can access the following: Intimate Partner Violence fact sheet; Making Changes; A book for women experiencing intimate partner abuse; Neighbours, friends, and families campaign material; Standing Together – Evaluation Summary report; Standing Together – Pathways for Change; Standing Together – Project Recipients; and Women's safety publications.

Ms. MacInnis-Langley stressed the need for continued intimate partner violence education. The access by the public including rural areas of Nova Scotia to the internet is far greater today than in 2016. Not many Nova Scotians would, off the top of their head, know of the 211 helpline compared to the 911 program. The 211 and public awareness of this and other programs that can be found on the internet needs to be widely known.

10. Recommendation: The Province of Nova Scotia should ensure that funding for the Men's Helpline through the Provincial 211 system continues, and work to increase public awareness of websites that provide information for those who encounter intimate partner violence.

The Inquiry heard extensively about intimate partner violence services available in Eastern Nova Scotia. Nancy MacDonald is the Executive Director of Family Services of Eastern Nova Scotia. She had held that position for twelve years at the time that she testified and had been employed with Family Services of Nova Scotia for twenty-four years.

Ms. MacDonald differentiated between mandated services related to family violence and self referrals.[137] Mandated services are those where individuals are required to attend counselling for intimate partner violence as part of a probationary sentence through Court order or required by child protection measures. She also identified that there is need for services whereby individuals can self refer when they feel they need it.[138]

One of the programs that was highlighted in Stephanie MacInnis-Langley's testimony was Neighbours, Friends, and Family. This program originated in 2012 and, at the time of Ms. MacInnis-Langley's testimony, there was a revamping by the Legal Information Society of Nova Scotia with culturally appropriate components in partnership with the Indigenous and African Nova Scotia Communities.[139]

The HAAC presented a panel of individuals of African heritage which included: Ms. Sharon Davis-Murdock, Co-President of the HAAC; Robert S. Wright, Executive Director of People's Counselling Clinic; Ms. Lana M. MacLean, Mental and Emotional Support Counsellor; and Ms. Cynthia Jordan, also Mental and Emotional Support Counsellor. All had extensive Curriculum Vitae's. Mr. Wright, in particular, is well regarded in the justice system.

Together the panel underscored the need for focused culturally specific service delivery to African Nova Scotians in the area of Intimate Partner Violence. These individuals also brought out the need for culturally specific training to health care providers generally.

[137] Transcript – September 15, 2021 – Pages 50-51
[138] Ibid – Page 51
[139] Transcript – September 14, 2021 – Page 63

As was stated by Ms. Davis-Murdock at page 21 of the transcript from November 29, 2021.

> Cultural competence talks about having a sense of the history and lived reality of the people that you are serving. It talks about understanding that one size does not fit all and that's where cultural specificity comes in and it talks about the need for planning and service delivery that responds to the unique needs of people. Anti-Black racism is a social and structural determinant of health. It is impacting the health of people of African ancestry in all ways and the constant, and I know that my colleagues have expertise in this area so I invite them to add to this, but the stress of living with anti-Black racism, you know, microaggressions on a daily basis and high level structural racism, which means that you have a system that doesn't meet your needs, that isn't represented by people who look like you at all levels let alone at the highest level of the system. That has an oppressive effect on people and, indeed, affects their health.[140]

Ms. MacDonald testified regarding the importance of the Men's Health Centre. She described the need for more spaces and that there is difficulty keeping up with requests. Ms. MacDonald stated:

> The Men's Health Centre tries to be grounded in the social determinants of health. So we try to make space for the fact that a loss of employment, the loss of a job, a loss of an income, a loss of a relationship, a new person to a town, culture, race, all of those social determinants of health are crucial to men or people who identify as being male.[141]

Family Services of Eastern Nova Scotia at times has employed a navigator through the Men's Health Centre to assist in connecting those who need it to appropriate services. It appeared that funding for this position was derived mainly through grants which are often finite.[142]

Throughout the evidence of the Inquiry there was testimony which touched on warning signs of Corporal Desmond's mental health deterioration and its impact on

[140] Transcript – November 29, 2021 – Page 21
[141] Transcript – September 15, 2021 – Page 57
[142] Transcript – September 15, 2021 – Pages 64-68

family violence**.** The importance of it to family, neighbours and friends cannot be understated; to be aware of how to reach out for help when observing intimate partner violence can be underrated. Further, that individuals should feel free to do so without guilt or concerns that they are overstepping their bounds.

In the report prepared for the Inquiry by the HAAC, entitled "The Desmond Inquiry – Lack of Appropriate Mental Health and Intimate Partner Violence Services to Black Nova Scotians as a Continuing Factor" quoted from an individual they had contacted as follows:

> Several of the participants described that for many of the young Blackmen in the communities going into the military in their words:
>
> > Was a way out of poverty and gave them a skill, pension so they could come home with something. But they [military] are also coming back home damaged and we can't help them down here. We don't know how to help these boys when they come home all messed up. All we can do is love them and try to get them to get some kind of help. They come back different and we [community] see the drinking, yelling going on and we do nothing because we don't know what to do… my own brother killed himself down here. We don't even have someone we can as a family to talk to we all down here are suffering, and no one can help.
> >
> > The AUBA sent folks down here to help us out when Lionel killed his family. But that was only short term. Our community needs more help, and we are forgotten down here too.
>
> Participants in the sessions across the province were unaware of the mobile crisis line operated by Nova Scotia. They also noted the lack of access to the service outside of the HRM stating, "it's not mobile down here for us." Many were aware of Kids Help Phone but did not know how to access the resources. They also acknowledged limited staffing at the local hospitals (Guysborough Memorial and St. Martha's) stating, "you're better off, if you can get a drive going to Sydney."

When examining the Neighbours, Friends and Family program Inquiry Counsel Shane Russell, asked Ms. MacInnis-Langley the following: "I'll use myself for example,

I didn't know of the existence of it. Where does the general population learn about this highly valuable information?" In response Ms. MacInnis-Langley stated: "Well first of all, I would say to you, you'd have to be looking for it."[143]

Aggravating this in racialized communities is the lack of mental health and addiction literacy.[144]

The evidence at the Inquiry made it clear that recognition of programs available to the public regarding intervention and assistance in matters of intimate partner violence are not well known unless there are intervening factors such as criminal charges or referrals to Child Protection. Additional information needs to be filtered through a cultural lens for racialized communities. Had the family and other community members felt more comfortable accessing intervention for Corporal Desmond when he "snapped," exploded, or showed other signs of possible pending violence, they may have taken steps to trigger intervention.

Overall, these would have been government and privately funded sources of assistance that would have been available to the Desmond family. Had those services been more widely known it is difficult to say whether the tragedy would have been averted. It appears with some certainty that wider public knowledge is important.

11. Recommendation: That the Province of Nova Scotia embark on a public information campaign across multimedia regarding avenues to access programs relating to intimate partner violence. Further that any

[143] Transcript – September 14, 2021 – Page 61
[144] Report of Health Association of African Canadians – Page 3

campaign be aware of, and referred to, African Nova Scotian needs and cultural identity.

Part VI

Whether Health Care and Social Services providers who interacted with Lionel Desmond were trained to recognize the symptoms of Occupational Stress Injuries or Intimate Partner Violence

Whether Health Care and Social Services providers who interacted with Lionel Desmond were trained to recognize the symptoms of Occupational Stress Injuries or Intimate Partner Violence

Corporal Desmond was first provided services related to OSI on September 28, 2011. From that date on the evidence provided to the Inquiry showed the depth and complexity of Corporal Desmond's mental health challenges. It became very apparent that Corporal Desmond would have required in depth, consistent, structured, and comprehensive mental health services if he were to obtain any measure of stability and functionality in his daily life. These services were at times available to him, while at other times, they were elusive.

Corporal Desmond was first referred for treatment of PTSD in late September 2011. He was referred to Dr. Vinod Joshi who was a consultant Psychiatrist with Mental Health Services with the CAF since 2007. In addition to Dr. Joshi, Corporal Desmond was treated therapeutically by Dr. Wendy Rogers. Dr. Rogers as well had an extensive background in her field of expertise.

Corporal Desmond's interaction with St. Martha's Regional Hospital staff appears to have been appropriate from a medical treatment point of view. He was seen by a psychiatrist and was allowed to remain in hospital as a social admission for the night.

He left on his own accord the next day. He was advised to maintain a follow up appointment with the psychiatrist.

These interactions also revealed a number of significant intimate partner violence risk factors in his personal life. Corporal Desmond was suffering from the symptoms of

PTSD and there was turmoil in the home. What, if anything, could medical staff have done with this information? Shanna Desmond was not with Corporal Desmond that night. Had she been present, further interaction with her may have been possible, but she was not. What the Inquiry has heard is that repeatedly professionals may not have fully grasped the numerous red flags for the risk of serious intimate partner violence or domestic homicide. Training in this area for all health care professionals may assist those professionals in recognizing the risk factors for intimate partner violence and giving them the tools to act.

Dr. Rogers worked with Corporal Desmond to assist him in dealing with the symptoms of his PTSD. In her evidence, she described the primary modalities of treatment used to treat the symptoms of PTSD in patients – cognitive processing therapy; prolonged exposure therapy; and eye movement desensitization reprocessing (EMDR). Between December 2011 and February 2013, Dr. Rogers met with Corporal Desmond regularly and employed a clinical approach involving prolonged exposure therapy. This approach was met with some success. While Corporal Desmond's
symptoms never fully subsided, there was improvement to the point that he was deemed ready to return to active duties.[145]

Despite this early success with therapy, his symptoms were once again triggered later in 2013 by an incident involving racial comments made by a colleague.[146] This underscored the tenuous nature of his mental health and the need for continued structured therapy and treatment. His symptoms waxed and waned during the remainder of his time in the CAF.

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[145] Exhibit – P-000222
[146] Exhibit – P-000223, P-000240

When released to live in the community in New Brunswick, Corporal Desmond was referred to the New Brunswick OSI Clinic. Corporal Desmond was treated by psychiatrist Dr. Anthony Njoku and psychologist Dr. Mathieu Murgatroyd between June 2015 and May 2016. His symptoms continued. For example, in the notes from his second therapy session with Dr. Murgatroyd in July of 2015, he is described as continuing to have what was described as "intrusive thoughts, disturbed sleep (including night sweats), paranoia and homicidal thoughts (without intent) . . . on [a] daily basis." [147]

The severity of his condition and his need for continued intensive treatment were described by Dr. Njoku in August of 2015 when he stated bluntly that Corporal Desmond was "still very severely suffering from his PTSD symptoms which don't really seem to have relieved much or perhaps [have] further exacerbated following release." He stressed the need for residential treatment.[148]

While in New Brunswick, Corporal Desmond also sought treatment from Dr. Paul Smith who prescribed medical marijuana to assist in alleviating his symptoms. He saw Dr. Smith between July 2015 and February 2016. The efficacy of this treatment was questionable and it was discontinued prior to his attendance at Ste. Anne's Hospital in Quebec. Dr. Rahman stated that there was a clear connection between his marijuana use and paranoia and jealousy regarding his wife. [149]

The Inquiry heard evidence regarding the process of Corporal Desmond being assigned a case manager by VAC, a process which was also ongoing at this time. Although an initial work item was created in May of 2015 directing that Corporal Desmond be referred "to a case manager to determine the need for case management or rehab program

[147] Exhibit – P-000244
[148] Exhibit – P-000244
[149] Transcript – February 4, 2020 – Page 72 and 83

support,"[150] he was not formally assigned a case manager until November 26, 2015. This was in spite of his desire to be assigned to a case manager to assist with transition and rehabilitation. The VAC running notes record multiple calls made by Corporal Desmond seeking assignment. [151] The Fall of 2015, after his release from the CAF, was a period of flux for Corporal Desmond and there was uncertainty about where he would be living. The course of his treatment and his need for continuous and structured care were impacted by the delays in the assignment of a VAC Case Manager.

Corporal Desmond was finally assigned to VAC Case Manager Marie-Paule Doucette in November 2015. At that time, Dr. Murgatroyd called Ms. Doucette to express concerns regarding Corporal Desmond's "instability" and his need for "coordinated support." Ms. Doucette's first contact with Corporal Desmond was on November 27, 2015.[152]

As evidence of Corporal Desmond's lack of stability at this time, it is on that same day – November 27, 2015, - that Shanna Desmond reported to police that she was receiving concerning texts from Corporal Desmond which suggested he was contemplating suicide. RCMP members attended at the residence in New Brunswick and took Corporal Desmond to hospital.

On December 1, 2015, Corporal Desmond communicated this experience to his case manager. Despite the nature of what had occurred in November, the next contact with the case manager was not until January 2016. On December 15, 2016, a recommendation was made to refer Corporal Desmond to the Ste. Anne's

[150] Exhibit – P-000290
[151] Exhibit – P-000273
[152] Ibid – Pages 16–17

Stabilization/Residential Program in Montreal. According to Dr. Murgatroyd, he continued to struggle with disabling symptoms of PTSD and had significant problems functioning in daily living. On January 16, 2016, Case Manager Doucette completed an assessment of Corporal Desmond's needs. On February 9, 2016, a VAC Progress Note stated that "efforts to treat [Corporal Desmond's] OSI have been unsuccessful given lack of emotional, mental and geographical stability."[153] There appears, however, to be limited stressing of the domestic problems faced by Corporal Desmond.

The most intensive, structured, and multi-disciplinary treatment that Corporal Desmond received came during the period he spent at the Ste. Anne's Hospital in Montreal from May 30, 2016, to August 15, 2016. The Inquiry heard that, while at this facility, Corporal Desmond worked with a psychiatrist, a psychologist, an occupational therapist, a social worker, an art therapist, a psycho-educator, a physical rehabilitation therapist and a general practitioner, among others. He was engaged first in a stabilization program and then in a residential treatment program. The level of engagement and therapy during this time was comprehensive and continuous.

Despite the numerous clinicians and the highly specialized nature of the treatment, when Corporal Desmond left the facility, he was still in need of further services and continued treatment and structure. The Discharge Summary dated August 17, 2016, spoke to this need, and made a myriad of recommendations designed to "ensure his continuity of care in his community." [154]

On August 9, 2016, a telephone conference was held among the Ste. Anne's team, Dr. Murgatroyd and his Case Manager, Marie-Paule Doucette. Among his numerous

[153] Exhibit – P-000117 – Page 5
[154] Exhibit – P – 000254 – Page 268-274

needs, there was discussion at this meeting of the need for a neuropsychological assessment and the assignment of a CCM. A CCM would work as an extension of the VAC Case Manager and would assist in stabilizing a veteran's situation and coordinating supports and services. In the VAC Case Plan,[155] Ms. Doucette noted, on August 10, 2016, that overall, Corporal Desmond had made only "minor progress" and that he had a lack of a sound plan upon discharge. The Discharge Summary from Ste. Anne's Hospital, which summarizes his course of treatment at the hospital and their general recommendations going forward was not sent to VAC and the NB OSI Clinic until October 7, 2016.[156]

To say that there was a gap in his treatment upon his discharge from Ste. Anne's Hospital and his relocation to Guysborough, Nova Scotia would be an understatement. Corporal Desmond came to Nova Scotia with no services or treatment plan in place. Nothing was arranged for on-going psychological counselling, medication compliance monitoring, social supports, or neuropsychological testing. Corporal Desmond's relationship with his wife was troubled and continued to deteriorate. For example, Ste. Anne's Social Worker, Kama Hamilton had arranged a telephone call between the two during which the couple displayed significant frustration and anger with each other. Shanna Desmond expressed the concern that Corporal Desmond remained too volatile and angry and was concerned that he would be unable to regulate his moods.[157] Nonetheless, Corporal Desmond returned to the Guysborough, Nova Scotia area and resumed living with his wife and daughter. The fact that Corporal Desmond was of a

[155] Exhibit – P-000117, Page 10
[156] Exhibit – P-000244 – Pages 84-91
[157] Exhibit – P-000254 – Pages 266-267

concern to his domestic partner ought to have raised many flags given he was going back to reside with her.

At the time of his relocation to Nova Scotia in 2016, the Nova Scotia OSI Clinic was still in its infancy. An inter-clinic referral was made to the Nova Scotia clinic by Dr. Murgatroyd on September 30, 2016. The evidence the Inquiry heard left some lack of clarity regarding the pre-requisites for treatment in Nova Scotia at that time. Whether it was a formal policy or not, there was a requirement that any client of the clinic be established with a family doctor prior to being seen by a psychiatrist. Corporal Desmond did not have a family doctor. Whether it was this requirement or concern regarding travel from Guysborough to Dartmouth, Corporal Desmond was unable to avail himself of assistance from the clinic.

Veterans Affairs Canada identified the need for a CCM for Corporal Desmond given his need for structured assistance and began to consider individuals who might be able to fill this role. Helen Luedee was identified in August 2016 as someone who might be appropriate. Ms. Luedee testified at the Inquiry that delays were occasioned based on her inability to navigate the VAC billing system. Corporal Desmond was only able to meet with Ms. Luedee for the first time on November 30, 2016, approximately three months after his return to Nova Scotia.[158]

Although he was able to access the medical clinic in Guysborough, he essentially had no family doctor familiar with his history or conditions. Doctors who met with him were left to guess at the medications he had been prescribed. Corporal Desmond was unfortunately an inaccurate historian of his medical care. He was not able to describe the

[158] Exhibit – P-000117 – Page 5

various diagnoses he had received or the forms of treatment he had undergone. He did not have access to his own medical records or the Discharge Summary from Ste. Anne's Hospital.

It seems obvious that had he had the Ste. Anne's Discharge Summary in hand, the tasks faced by clinicians in Nova Scotia would have been much clearer. For example, Corporal Desmond and Shanna Desmond attended the Guysborough Medical Clinic on October 13, 2016, and saw Dr. Luke Harnish. According to Dr. Harnish, Corporal Desmond was wondering about his follow-up plan after coming out of Ste. Anne's and "didn't know where else to turn."[159]

Corporal Desmond was left to attend the Emergency Department of St. Martha's Hospital which he and Shanna did on October 24, 2016. He was seen by Dr. Ian Slayter and Mental Health Nurse, Heather Wheaton. His untreated mental health symptoms were severe. Dr. Slayter expressed concern regarding his follow-up and that he needed to be seen soon. [160]

Corporal Desmond was seen again by Dr. Slayter on December 2, 2016, for a longer appointment. Despite a complete lack of access to medical records, Dr. Slayter was able to obtain a partial history and make a number of diagnoses. He stressed the need for an intensive treatment and rehabilitation program, intensive psychotherapy for his PTSD and jealousy regarding his wife, and a neuropsychological assessment. And in a conclusion that was both accurate and prescient, he described Corporal Desmond as "falling through the cracks in terms of follow-up by military and veteran program."[161]

[159] Transcript – March 10, 2021 – Page 137
[160] Transcript – February 10, 2020 – Page 48
[161] Exhibit – P-000067 – Pages 26 - 28

The Desmond tragedy can be described in many ways as many things. Clinically, Dr. Scott Theriault said that the tragedy best fit the "profile of a homicide-suicide of familicide-suicide type."[162] Ultimately, it was the most extreme manifestation of family violence imaginable.

Corporal Desmond's diagnosis of PTSD was well-established and known to health care providers from 2011 onward. There were, however, many issues with which Corporal Desmond struggled and they did not exist in water-tight compartments. His PTSD was only a part of his complex clinical and personal presentation. While those who dealt with him and treated him understood his PTSD diagnosis, they did not always see or understand that his family life was deteriorating and was becoming dangerous. Corporal Desmond harboured an increasing suspicion of, and, at times, resentment toward his wife. As he struggled with his symptoms and the lack of direction in his life, Shanna was embarking on a new career as a registered nurse. She was becoming exhausted dealing with his mood swings and outbursts and the couple appeared to be nearing a separation. The lack of clarity in his thought process left Corporal Desmond with suspicions of his wife's fidelity that, while not frank delusions in the opinion of Dr. Slayter, were certainly overvalued and without basis. At times, he could understand that the suspicions about his wife were baseless – at other times he could not.

The Inquiry heard evidence from Dr. Peter Jaffe, one of the country's pre-eminent experts on the issue of intimate partner violence. Dr. Jaffe had the opportunity to review

[162] Exhibit – P-000328 – Page 23

much of the relevant evidence called by the Inquiry. In his testimony and in the report he prepared for the Inquiry,[163] Dr. Jaffe stated frankly:

> The January 2017 triple homicides and suicide committed by Cpl. Desmond that took the lives of his wife, Shanna, their 10-year-old daughter Aaliyah, and his mother Brenda seem entirely predictable and preventable with hindsight. This hindsight is clear in the context of all the information available about the serious risks that Cpl. Desmond was presenting and the history that could have been known to professionals as well as family and friends. Although it may have been difficult to predict exactly when and how these events would unfold, Cpl. Desmond and his family seemed on a clear path for a horrific tragedy based on all available information reviewed by the Inquiry.

Of the forty-one risk factors associated with domestic homicide utilized by the Ontario Domestic Violence Death Review Committee, Corporal Desmond presented with twenty according to Dr. Jaffe. Among them were some of the risk factors seen with most frequency in domestic homicides. They included: a history of intimate partner violence; a pending separation; the perpetrator suffering from depression; and prior threats by the perpetrator to commit suicide.[164]

Dr. Jaffe noted that Corporal Desmond interacted with a multitude of professionals – as many as forty medical practitioners, mental health professionals, and police who had “exposure to aspects of the stressful circumstances and accumulating risks that Cpl. Desmond was presenting.” However, each professional seemed to assess the risk factors that Corporal Desmond presented in isolation.[165]

One of the most troubling aspects of the history of Corporal Desmond’s treatment was the lack of understanding that intimate partner violence was very much present in

[163] Exhibit – P-000334
[164] Exhibit – P-000339
[165] Exhibit – P-000334 – Page 27

the Desmond relationship and that it posed a real and objectively measurable increased risk of harm. Dr. Jaffe noted at page 11 of his report:[166]

> Domestic homicides appear to be [the] most predictable and preventable of all homicides. Friends, family, coworkers, professionals who had contact with the victim and/or perpetrator often report warning signs that had concerned them. Often friends and family did not know what to do or say. They may have been hesitant to share their observations and worries. **Frontline professionals may have lacked awareness or training about domestic violence warning signs.** Many people wish they had taken action such as speaking to the victim or the perpetrator and encouraging them to get help. Some wished they had called the police or engaged the justice system much earlier for protection. [Emphasis added]

Based on his review of Inquiry evidence, Dr. Jaffe stated that "from 2011 to 2017, no one really addressed the extent of intimate partner violence and abuse." Rather, Dr. Jaffe states "multiple euphemisms" were used to describe the marital issues. This, he said, was a function of several common misunderstandings about intimate partner violence that were exhibited by the professionals and service systems involved with the Desmond family." [167] Dr. Jaffe stated at page 22:

> In my file review, I found several common misunderstandings about domestic violence that were exhibited by the professionals and service systems involved with the Desmond family. In my opinion, these misunderstandings undermined the potential for better assessments of the serious risks and appropriate interventions required. The terms violence and abuse were rarely used or expanded upon in interviews with both Lionel and Shanna Desmond. The problem was not named. There was a focus on mental health alone and not the impact of Cpl. Desmond's suicidal behaviour and other symptoms on his wife and daughter. His suicidality was a potential risk for both himself and for others in his life and there needed to be more done to manage risk to all involved. [168]

Additionally, Dr. Jaffe noted that Shanna Desmond's perspective was rarely sought by professionals, that when the topic of abuse was approached, it was focused on physical

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[166] Ibid – Page 11
[167] Exhibit – P-000334 – Page 22
[168] Ibid – Page 22

abuse rather than recognizing the multiple forms of intimate partner violence, and that Corporal Desmond's presenting problems were seen as either mental health or intimate partner violence but not both. He notes that "none of the professionals involved consider[ed] the need for [a] specialized intimate partner violence program for abusers as a complement to other treatments." [169]

Several of the medical and mental health professionals who testified at the Inquiry acknowledged they would benefit from additional training or continuing education in the area of intimate partner violence.[170] This is an area in which Dr. Jaffe made recommendations, specifically, that professional education on intimate partner violence and domestic homicide be expanded.[171] Dr. Jaffe lists the elements of this professional education and training. Additionally, Dr. Jaffe recommends that the schools of Social Work, Psychology and Medicine need to ensure courses are provided on intimate partner violence and risk assessment and management and that the regulating bodies and professional associations for these professional groups provide ongoing professional development on intimate partner violence.

12. Recommendation: Ensure that frontline professionals in multiple systems such as health, mental health, education, social services, and the justice system are up to date with current information about intimate partner violence, the dynamics in these relationships, the impact of intimate partner violence on children and the potential for lethality in

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[169] Exhibit – P-000334 – Page 23
[170] Transcript – Dr. Slayter – February 10, 2020 – Page 138, 150-151;
Transcript – Dr. Rahman – February 4, 2020 – Pages 160, 176
[171] Exhibit – P-000334 – Page 30

these cases. This should include an awareness of risk factors, risk assessment, safety planning and risk management strategies.

Shanna Desmond herself appears to have only begun to comprehend the danger that she and her child were in near the end of her life. Her first and only call to the Naomi Society in Antigonish, a not-for-profit organization providing services to women and children who have experienced intimate partner violence in the Antigonish-Guysborough area, was on the afternoon of January 3, 2017. According to the notes made by Executive Director Nicole Mann, with whom she spoke, Shanna Desmond requested and received information but was not yet ready to make an appointment.[172]

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

> Shanna Desmond did reach out regarding the suicide threats and access to weapons, but the matter should have been red flagged at that point for follow-up and separate interviews with her and him. There could have been a "warm handoff" to victim services rather than just providing a business card. [173]

One of the obvious entry points for families to access intimate partner violence intervention services occurs when police are called. The Inquiry heard evidence that police agencies interacted with the Desmond family on several occasions. Police were called for wellness checks on Corporal Desmond regarding his expressions of suicidal ideation, his anger and, once, because Corporal Desmond himself believed that Shanna Desmond had left him and was ending their marriage. None of these interactions resulted

[172] Exhibit – P-000078
[173] Exhibit – P-000334 – Page 26

in charges under the *Criminal Code of Canada*. Indeed, there was nothing reported to police that necessarily should have resulted in criminal charges. And yet, in retrospect, each of these interactions were replete with warning signs about risks for intimate partner violence and domestic homicide.

The Inquiry has received information regarding the training that police in this province receive when they are called upon to deal with calls of a domestic nature where intimate partner violence may be occurring. The Inquiry heard evidence from Sharon Flanagan, Senior Lead, Policing and Public Safety Division, Department of Justice. In terms of the use of intimate partner violence risk assessment instruments, Ms. Flanagan testified that all police agencies in the Province of Nova Scotia employ the Ontario Domestic Assault Risk Assessment (ODARA) to assess risk in intimate partner violence cases. This is a consistent policy employed by all police agencies; however, it is not mandated by a policing standard. In fact, there is no policing standard in Nova Scotia regarding investigations of intimate partner violence or the use of an intimate partner violence risk assessment tool. The ODARA is a tool that was designed to predict the risk of recidivism in cases of domestic assault.[174]

The importance of an intimate partner violence risk assessment tool was underscored by Dr. Jaffe in his testimony.[175] The Inquiry heard that multiple intimate partner violence risk assessment tools are available such as the ODARA, the Jacquelyn Campbell Danger Assessment, and the Domestic Violence Risk Management (DVRM) Report[176] which is the tool used throughout Ontario. The appropriateness of a particular instrument can depend on the context.

[174] Transcript – March 21, 2022 – Page 194
[175] Transcript – November 3, 2021 – Page 165
[176] Exhibit – P-000356

The uniform and consistent use of an intimate partner violence risk assessment tool by police in cases of a domestic nature that do not ultimately result in criminal charges but where concerning behaviour related to an intimate partner is present, would have value. This would provide for the opportunity to identify risk factors and engage with a domestic partner who may benefit from a "warm hand-off" to another agency or to the Victim Services Domestic Violence Coordinators who work with the various police agencies.[177] A comprehensive domestic risk assessment tool such as the DVRM Report[178] used in Ontario (which incorporates the ODARA instrument) may be particularly well-suited.

13. Recommendation: That Nova Scotia institute a police standard requiring all police agencies to utilize an intimate partner violence risk assessment tool (such as the DVRM) in all calls and investigations involving domestic conflict where concerning behaviour regarding an intimate partner is present irrespective of the existence of a criminal charge.

In his report to the Inquiry, Dr. Jaffe also referenced Nova Scotia's High Risk Case Coordination Protocol and expressed the opinion that there were missed opportunities to use this protocol. He felt that the Desmond family's situation represented "a high-risk case that needed to be flagged and enhanced coordination efforts were required among the police, victim services, social services, mental health and health care professionals."[179]

Dr. Jaffe recommended the Nova Scotia Departments of Justice and Community Services update the high-risk protocol to deal with cases where there is no criminal offence but there is concerning behaviour related to the intimate partner. Dr. Jaffe also

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[177] Transcript – March 21, 2022 – Pages 39-40
[178] Exhibit – P-000356
[179] Exhibit – P-000334 – Page 32

referred to the newly created Highest Risk Domestic Violence Table, a new initiative in Nova Scotia. In their March 11, 2022 brief to the Inquiry,[180] counsel for the Province of Nova Scotia described the Provincial Highest Risk Domestic Violence Table and noted that the Table "is intended to enable service providers and others to evaluate situations where there are intimate partner violence concerns about imminent risk of serious bodily harm or death" and that referrals to the Table can be made even if a police report or child protection report has not been made.[181]

14. Recommendation: The Nova Scotia Departments of Justice and Community Services review the High-Risk Case Coordination Protocol to deal with cases in which there is no criminal offence but there is concerning behaviour related to the intimate partner.

[180] Exhibit – P-000377
[181] Ibid – Page 34

Part VII

Given Nova Scotia Administration of the Canadian Firearms Program – Whether Lionel Desmond should have been able to retain, obtain, or purchase a firearm

Given Nova Scotia Administration of the Canadian Firearms Program – Whether Lionel Desmond should have been able to retain, obtain, or purchase a firearm

On the afternoon of January 3, 2017, at about 4:00 p.m. Corporal Desmond attended the premises of Leaves and Limbs Sports in Lower South River, Antigonish, Nova Scotia. There Corporal Desmond browsed the gun section for about twenty-two minutes. He then went to the cash. He ultimately purchased a SKS 7.62 Model 2210 which was a non-restricted weapon together with a box containing 50 rounds of ammunition.

Corporal Desmond paid cash for the gun and ammunition obtaining a receipt at 4:15 pm. Less than two hours later, he used the weapon to kill his wife, mother, daughter and himself.

The owner and salesperson, Daniel Kulanek, testified at the Inquiry. He described Corporal Desmond as "very relaxed, calm and no anxiety, no desire to get past...He was very patient."[182]

Corporal Desmond had a Possession and Acquisition Licence (PAL). Like a driver's licence, people who possess a PAL are issued a card. Mr. Kulanek stated he would never let a customer handle a firearm unless he was first shown a PAL card.

Mr. Kulanek also made sure to view the expiry date of the licence and that there was a legitimate licence number attached. In short, Mr. Kulanek did everything he was required to do to sell a firearm. In fact, he did more then required when he interacted with Corporal Desmond.

[182] Transcript – February 25, 2020 – Page 209

How did it come to be that Corporal Desmond, with his long history of PTSD and mental health issues, had a valid PAL on January 3, 2017? Corporal Desmond served in active combat in Afghanistan and was no stranger to weapons.

Corporal Desmond made his first application for a firearms licence on December 29, 2008. The licence was issued on January 15, 2009. This was two years prior to his diagnosis of PTSD. He applied for a renewal of his PAL on February 27, 2014.

Before looking further at the application that was made by Corporal Desmond it may be beneficial to have an overview of the application process itself and how the *Firearms Act* deals with eligibility to obtain a PAL.

In Canada, possessing and acquiring a firearm is, like a driver's licence, a privilege and not a right. The regime set out by the *Firearms Act* creates eligibility criteria for accessing and renewal of firearms licences.

Section 5 of the *Firearms Act* provides as follows*:*

> **5 (1)** A person is not eligible to hold a licence if it is desirable, in the interests of the safety of that or any other person, that the person not possess a firearm, a cross-bow, a prohibited weapon, a restricted weapon, a prohibited device, ammunition or prohibited ammunition.
>
> **(2)** In determining whether a person is eligible to hold a licence under subsection (1), a chief firearms officer or, on a reference under section 74, a provincial court judge shall have regard to whether the person
>
> **(a)** has been convicted or discharged under section 730 of the *Criminal Code* of
>
> **(i)** an offence in the commission of which violence against another person was used, threatened, or attempted,
>
> **(ii)** an offence under this Act or Part III of the *Criminal Code*,
>
> **(iii)** an offence under section 264 of the *Criminal Code* (criminal harassment),
>
> **(iv)** an offence relating to the contravention of subsection

> 5(1) or (2), 6(1) or (2) or 7(1) of the *Controlled Drugs and Substances Act*, or
>
> **(v)** an offence relating to the contravention of subsection
>
> 9(1) or (2), 10(1) or (2), 11(1) or (2), 12(1), (4), (5), (6) or (7), 13(1) or 14(1) of the *Cannabis Act*;
>
> **(b)** has been treated for a mental illness, whether in a hospital, mental institute, psychiatric clinic or otherwise and whether or not the person was confined to such a hospital, institute or clinic, that was associated with violence or threatened or attempted violence on the part of the person against any person;
>
> **(c)** has a history of behaviour that includes violence or threatened or attempted violence or threatening conduct on the part of the person against any person;
>
> **(d)** is or was previously prohibited by an order — made in the interests of the safety and security of any person — from communicating with an identified person or from being at a specified place or within a specified distance of that place, and presently poses a threat or risk to the safety and security of any person;
>
> **(e)** in respect of an offence in the commission of which violence was used, threatened, or attempted against the person's intimate partner or former intimate partner, was previously prohibited by a prohibition order from possessing any firearm, cross-bow, prohibited weapon, restricted weapon, prohibited device, or prohibited ammunition; or
>
> **(f)** for any other reason, poses a risk of harm to any person.
>
> **(2.1)** For greater certainty, for the purposes of paragraph (2)(c), threatened violence and threatening conduct include threats or conduct communicated by the person to a person by means of the Internet or other digital network.

Under the *Act*, the Chief Firearms Officer (CFO) determines the applicant's eligibility to hold a firearms licence and can either issue, refuse to issue, renew, or revoke a licence.

Provincial governments have the discretion to administer portions of the *Firearms Act* within their province. This would include licensing. As a consequence, Corporal Desmond would have been under the umbrella of both New Brunswick and Nova Scotia regarding issuing and renewal of PALs.

On February 27, 2014, Corporal Desmond applied to renew his firearms. This application was for both restricted and non-restricted firearms.[183]

The application involved the question: "16(d) During the past five (5) years, have you threatened or attempted suicide, or have you been diagnosed or treated by a medical practitioner for: depression, alcohol, drug or substance abuse, behavioural problems or emotional problems." Corporal Desmond answered "No" to this question.

At this point Corporal Desmond was under the care of Dr. Joshi for his PTSD diagnosis. As well, it was documented in the application for Possession and Acquisition Licence, that as of October 29, 2013, Corporal Desmond's mental health had continued to deteriorate, and he had increasingly frequent suicidal ideation and homicidal ideation. Part of the plan included in the report was that he was not to handle live ammunition. Corporal Desmond clearly provided false information on his firearms application. [184]

Corporal Desmond's application was received on March 3, 2014, by the CAF. In his application Corporal Desmond had put forward his wife Shanna as a reference. Spouses were not eligible for acting as a reference, so a further reference individual was required. One of the references provided by Corporal Desmond gave information that Corporal Desmond had been diagnosed with PTSD.[185]

The disclosure of a PTSD diagnosis triggered a review of the application for a PAL renewal. As part of the review, a registered letter was sent to Corporal Desmond

[183] Exhibit – P-000130, Page 7
[184] CAN001996 – October 29, 2013
[185] Exhibit – P-000131

together with a medical assessment form for signature by a physician.[186] That form was returned signed by Dr. Joshi. Dr. Joshi checked the box: "No, I have no concerns that the applicant named above may pose a safety risk to himself and others."

The Firearms Officer assigned to the matter, Joe Roper, followed up with a call to Dr. Joshi. The doctor told Officer Roper that he had been treating Corporal Desmond for four and a half years, that he was medicated, that he had no psychosis and that he had "never mentioned self harm or any violent ideation."[187] This form was returned on November 12, 2014.

The response from Dr. Joshi is surprising given the history of his treatment of Corporal Desmond and other documentation. As previously mentioned, it was documented that at the end of October 2013, Corporal Desmond was deteriorating with increasing frequencies of homicidal and suicidal ideation. Dr. Gilbride, also a CAF doctor, was approached by Corporal Desmond to have paperwork completed for the office of the Provincial Firearms Officer. Dr. Patrick Gilbride noted that it was his first time seeing Corporal Desmond and that Corporal Desmond had PCat completed with an ARMEL decision in May of 2014 stating he was not fit to safely handle a personal weapon.[188]

Dr. Gilbride advised Corporal Desmond that he could not sign off the paperwork that day, the October 22, 2013, but would ask Dr. Joshi to assess and complete the paperwork as appropriate at their next appointment. Corporal Desmond denied any suicidal or homicidal ideations at that meeting.

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[186] Ibid
[187] Exhibit – P-000136
[188] Exhibit – P-000186

Dr. Joshi was asked about the reasons he gave for his opinion that Corporal Desmond was safe to have a gun.

He stated the following:

> So by that time in October and … so by that time, Cpl. Desmond was functioning better. He had … he was stable. He was not having any major problems. He was feeling good. He was enjoying his workplace. There was no concern about suicide or violence. He was thinking about future and he was happy about getting two-year retention at that point and he had a good summer. So with that, he seems like he was stable for a period of time.[189]

With respect, it is difficult to reconcile Dr. Joshi's opinion that Corporal Desmond had a "good summer," with Corporal Desmond still being under Medical Employment Limitations (MEL) that would not allow him to have a weapon. At minimum advising the Firearms Officer of the MEL may have resulted in further inquiry by the NBCFO as to the suitability of Corporal Desmond to possess a firearm of any kind.

There has to be recognition that information such as Dr. Joshi provided was based on the information available at the time. If someone is stable at the time the question becomes what if the stability falls apart? Clinicians are not able to predict the future. Ascertaining future risk based on past background is not an unknown practice to medical practitioners. Medical personnel routinely provide information to patients to obtain informed consents which can involve advising of possible risks of procedures as well as estimates of probabilities of remission and other medical concerns.

The Inquiry received evidence regarding interactions between Corporal Desmond and policing agencies. These interactions resulted in what is known as a

[189] Transcript – February 23, 2021 – Page 102

Firearm Interest Police (FIP). A description of a FIP and how it functions within a Firearms Officer's determination as to granting or renewing a PAL was described by Lysa Rossignol.[190] Ms. Rosignol was, at the time of testimony, the Acting Chief for the New Brunswick Provincial Firearms Office.

FIPs are created when a policing agency is investigating or are called to an event. Events are coded using a Uniform Crime Reporting or "UCR" code. FIPs can be part of that coding. The codes are entered into a computer database known as the Canadian Police Information Centre database or "CPIC." Information in CPIC will be automatically communicated to the Canadian Firearms Information System or "CFIS." This will be communicated to the CFO for the applicable province. This will trigger an investigation to determine if the subject of the FIP is a licence holder and, if so, how this might affect their licence during the period of investigation.[191]

On November 18, 2015, Shanna Desmond contacted police for a wellness check on Corporal Desmond. Her concern was his manic behaviour and that he had left the residence. Corporal Desmond's Mental Health Worker advised Shanna that her husband should be brought into the hospital. Staff Sergeant Addie MacCallum responded. As a result of this Staff Sergeant MacCallum created a FIP. Ultimately the wellness call was dealt with. The CFO's office in New Brunswick had no initial awareness of this FIP and it would not have come to their attention but for a subsequent event in New Brunswick which created a second FIP.[192] This is due to the first FIP being in another province.

[190] Transcript – February 19, 2020 – Page 48
[191] Transcript – February 19, 2020 – Pages 48-53
[192] Ibid – Page 175

The second FIP was created again as a result of an RCMP wellness check on Corporal Desmond, this time in his New Brunswick residence. The occurrence date was November 27, 2015, a little over a week after the earlier interaction with the RCMP in Nova Scotia. Shanna Desmond was receiving text messages from her husband that suggested he was contemplating suicide. This was reported to the RCMP in New Brunswick who did a check on Corporal Desmond which caused them to create a FIP.

This FIP was received by the CFO in New Brunswick, at which time Corporal Desmond's licence was placed under review. The review was assigned to Firearms Officer Joe Roper. Officer Roper forwarded a letter to Corporal Desmond asking him to have the "Medical Assessment by Physician Form" completed. At that time, the NBCFO was unaware of the November 18, 2015, incident in Nova Scotia. Dr. Smith, as well, was unaware of the Nova Scotia incident when Corporal Desmond took the form to him. Dr. Smith completed the form and advised that there was "no concern for firearm usage with appropriate licence."[193] It should be noted that Dr. Smith had Corporal Desmond complete a "PTSD Related Questionnaire" on July 5, 2015, where Corporal Desmond placed suicide as a symptom of five out of ten.[194] Even a moderate risk of suicide would have been something worth mentioning to the Firearms Officer.

At this time, the New Brunswick CFO office was seeking disclosure from the RCMP regarding the November 18, 2015, incident in Nova Scotia. That information was not received until April 14, 2016. The NBCFO was clearly dependant on receiving this information indirectly from another province.[195]

[193] Exhibit – P-000140 – Page 18
[194] IBID – Page 12
[195] Transcript – February 19, 2020 – Page 186

15. Recommendation: That Nova Scotia Chief Firearms Officer work with other provinces to ensure that processes are in place to notify when clients of this and other provinces are involved in events that create FIPs in the CFO's province and to ensure that information is shared in a timely manner.

November 28, 2015, saw Corporal Desmond return to Nova Scotia from New Brunswick. An Occurrence Report generated by the RCMP summarized that Corporal Desmond was complaining that Shanna had taken a firearm and tools from his vehicle.

Constable MacDonald, who received the complaint, noted Corporal Desmond as being "elevated and upset" at the onset of their conversation. The officer was aware Corporal Desmond was suffering from a stress injury related to his tour in Afghanistan and under treatment for the same.

Due to the domestic nature of the occurrence, with a verbal dispute between the spouses, Corporal Desmond's mental health difficulties and the involvement of a firearm, Constable MacDonald obtained backup to attend with him.[196]

The RCMP occurrence report went on to state:

> Cst. MacDonald walked to the adjacent property owned by Shanna Desmond's father Richard Borden so he could speak with Shanna Desmond about the firearm. Cpl O'Blenis stayed with Lionel Desmond.
>
> Cst. MacDonald and Shanna Desmond spoke at length about the events that led to the occurrence and she advised that she contacted Ormoncto RCMP the day prior after getting texts from Lionel Desmond suggesting he may have suicidal thoughts and might harm himself. Shanna Desmond advised that the Oromoncto RCMP located Lional Desmond and detained him under Provincial mental health legislation to ensure his safety and as a result of his detention a firearm in his Ormoncto home was seized for safekeeping. Shanna Desmond also advised that Cpl Arbour of the Ormoncto RCMP had asked her to secure Lionel Desmond's only other firearm from his aunts home in Upper Big

[196] Exhibit – P-000087 – Page 3

> Tracadie until Lionel Desmond's mental well being could be assured. Shanna Desmond told Cst. MacDonald she took the firearm from the home at 15371 16 Highway Upper Big Tracadie, NS and left it with her friend Thomas Gero as she could not leave it at her father's home as no one there owned a firearms possession licence.
>
> Cst. MacDonald and Shanna Desmond resolved at the instance of Cst. MacDonald to have the firearm she secured with Thomas Gero turned over to the Guysborough District RCMP to ensure it was kept in a safe location. Cst. MacDonald then answered questions asked by Shanna Desmond about how the process of the peace bond process worked. Cst. MacDonald provided Shanna Desmond information and then referred (provided card and read referral permission request) Shanna Desmond to Lori Castle of the Naomi Society. Shanna Desmond would not agree to the referral but accepted the card and advised she would peak with the Naomi Society on her own time.[197]

Despite the foregoing, this incident did not generate a FIP. It is recognized that not every police incident would generate a FIP, however, had these events been coded in a way that if they did create a FIP, it would have generated important information for the CFO to consider. The importance of UCR coding cannot be overstated.

16. ***Recommendation: That Police Officers in Nova Scotia receive additional training on proper UCR coding***.

It is crucial that CFOs have accurate and timely access to the information surrounding a police investigation that results in a FIP. A FIP leads to a review of the individual's licence. A standard that appears to be universal with Canadian CFOs.[198]

Access to police databases by CFOs was shown to the Inquiry to be at times problematic. In his testimony, Joe Roper of the NBFO highlighted that one of the biggest deficiencies he saw when he was an officer was lack of access to PROS.[199]

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[197] Exhibit – P-000087 – Page 3
[198] Transcript – March 2, 2020 – Page 54-55
[199] Ibid – Pages 40-42

17. Recommendation: That the Provincial Government advocate with the Federal Government to have federal policing agencies provide firearms officers access to the federal police database (PROS).

18. Recommendation: That the Provincial Government ensure all steps be taken to have expedited access by the CFO to various police databases including PROS, Versades (HRPD) and Niche (CBRP).

Corporal Desmond's attendance at Leaves and Limbs Sports to purchase the firearm on January 3, 2017, has been described earlier. What should be noted is that the store owner asked for and was shown Corporal Desmond's PAL. He ensured that the PAL was not expired, and that the person depicted on the licence was in fact the person before him. Both of those steps were required by law. While not required by law the owner of Leaves and Limbs Sports, Daniel Kulanek, also recorded the licence number and expiry date of the PAL and cross referenced this data to the serial number of the gun sold.[200]

At the time of sitting by this Inquiry, the provisions of *Bill C-71* an *Act* to amend certain Acts and Regulations to firearms, s.c. 2019, c.9, had not been fully proclaimed. Since then, two elements were brought into force via Order in Council of July 7, 2021. These allowed for expanded background checks to determine eligibility from the previous five years to the entirety of a person's life and widened eligibility screening to include whether the applicant has a history of harassment or restraining order, or pose a danger to any other person. There was a further re-instatement of the requirement

[200] Transcript – February 25, 2020 – Page 246

for a separate authority to transport when transporting restricted and prohibited firearms to any place except to an approved shooting range or to bring the firearm home after purchase.

Not proclaimed yet are the provisions for licence verification and business record keeping. These provisions would require the vendor to verify the firearms licence of the buyer with the Registrar of Firearms before transferring a non-restricted firearm. The buyer would be required to provide the vendor the information on the front of the licence card and that the vendor would be required to verify the identity of the buyer.

As well, the business record keeping provision under *Bill C-71* would require that characteristics of the firearm be recorded and retained for twenty years.

19. ***Recommendation: That the Province of Nova Scotia encourage the Federal Government to proclaim in force those provisions of Bill C-71, an Act to amend certain Acts and Regulations in relation to firearms, s.c. 2019, c.9, related to licence verification and business record keeping***.

It is telling that in the aftermath of the January 3, 2017, tragedy the former NBCFO dealt with the matter in an e-mail dated January 9, 2017. In that e-mail the following was stated:

> CFO's currently place a top priority on addressing all mental health information received, however most interactions with medical practitioners do not come to their attention unless self-disclosed by the client…"

It should be noted that the *Firearms Act* authorizes CFOs to require an applicant to submit information to determine eligibility to hold a licence under s. 55(1).

Section 55(1) and (2) provide as follows:

> **55** **(1)** A chief firearms officer or the Registrar may require an applicant for a licence or authorization to submit such information, in addition to that included in the application, as may reasonably be regarded as relevant for the purpose of determining whether the applicant is eligible to hold the licence or authorization.
>
> **(2)** Without restricting the scope of the inquiries that may be made with respect to an application for a licence, a chief firearms officer may conduct an investigation of the applicant, which may consist of interviews with neighbours, community workers, social workers, individuals who work or live with the applicant, spouse or common-law partner, former spouse or former common-law partner, dependants or whomever in the opinion of the chief firearms officer may provide information pertaining to whether the applicant is eligible under section 5 to hold a licence.

The Inquiry learned of Corporal Desmond's military history including being assigned an MEL, indicating he was not allowed to handle weapons.

Firearms Officer Roper testified that he was unaware of the existence of Armed Forces MELs. Further that, if the military would not allow members to use or possess a firearm, that "that would weight greatly on a decision whether or not they should have a licence."[201]

20. Recommendation: That the Provincial Government advocate the Federal Government to add under section 16(a) of the Application for a Possession and Acquisition Licence under the Firearms Act a provision that applicants must disclose any employment restrictions regarding firearms or weapons.

Once a PAL is issued, the only way in which that licence can come under further scrutiny by the CFO is if information of concern comes to the attention of the office of the CFO. Often this is from a FIP, but as shown not every interaction with police will

[201] Transcript – March 23, 2021 – Pages 134-135

result in a FIP being generated. Obviously if a PAL is granted, the flow of timely information into the hands of the CFO needs to be facilitated to properly assess continuing eligibility.

An argument can be made that a document in the form of an enduring authorization and consent or direction, could be provided by a patient to a doctor. This would allow a CFO to periodically request medical information during the period of the licence and that would allow the treating physician to report changes in the client's health status. In providing his thoughts on this issue, Nova Scotia CFO, John Parkin expressed what could be characterized as qualified support for this idea. [202] When asked if there would be value in "medical practitioners advising firearms officers of a change in [the] mental health circumstances of their patients or that the client . . . are no longer a patient during the five-year period that the firearms licence is valid," Mr. Parkin answered affirmatively. When asked what that value would be, he said:

> The value is in that we rely on external sources to provide us with a lot of the, for lack of a better word "alerts" when an individual is experiencing crisis or when there are difficulties, to bring it to our attention.
>
> For example, there's more than 75,000 licence holders in Nova Scotia at the present time. We have a staff of nine people, effectively, to monitor those individuals for any signs of distress or anything else that's going on. So we rely upon external sources of information to come to us and let us know that there is possibly a public safety risk or an individual who is at risk.[203]

21*. *Recommendation: An applicant for a firearms licence or a renewal of a firearms licence should be required to give an enduring consent and direction to the Office of the Chief Firearms Officer to allow follow up with a medical practitioner at any time during the period that the

[202] Transcript – March 22, 2022 – Pages 5 - 13
[203] Transcript – March 22, 2022 - Page 7

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

22. Recommendation: The Chief Firearms Office should, in appropriate cases, place certain licences under review and seek additional medical information, if necessary, to ensure that applicants who have been granted licences are continuing to meet eligibility requirements and are maintaining good mental health.

23. Recommendation: The Office of the Chief Firearms Officer should receive additional funding to facilitate additional and on-going checks of the mental health status of licencees.

PART VIII

What restrictions, if any, applied to accessing Federal health records of Lionel Desmond by Provincial health authorities or personnel

What restrictions, if any, applied to accessing Federal health records of Lionel Desmond, by Provincial health authorities or personnel

During the period Corporal Desmond was in active service with CAF to January of 2017, he was involved with a myriad of health care professionals. When Corporal Desmond presented at St. Martha's Regional Hospital on January 1, 2017, there would have been medical records relating to him in the following entities:

- Department of National Defence
- Canadian Armed Forces
- Veterans Affairs Canada
- New Brunswick Operational Stress Injury Clinic
- Dr. Paul Smith
- Dr. Everette Chalmers Regional Hospital
- Ste. Anne's Hospital
- Cathrine Chambers
- Guysborough Medical Clinic (Dr. Mahendrarajah and Dr. Harnish), and
- Nova Scotia Health Authority (i.e. Guysborough Clinic and St. Martha's Hospital)

This wide range of record location was far from unique to Corporal Desmond or veterans generally. In 2017 it would potentially be the same issue for tourists, out of province students, residents of Nova Scotia who have travelled outside the province and even Nova Scotian's who have relocated within the province.

Throughout the Inquiry evidence from witnesses made it apparent that full and complete medical histories can greatly increase the efficiency of treatment. This flow of information was sporadic and difficult to access for those treating Corporal Desmond.

The testimony of Dr. Ian Slayter at the Inquiry provides an insight into this problem. Dr. Slayter stated that regarding treatment of Corporal Desmond:

There were a lot of options. I wanted to know what his past treatment had been, also what problems he'd had before that I identified with.

Q. Right, okay. One of the things that you had wanted him to do and you say in your note: "I had asked him to obtain his military medical records so that I can review his medication history before considering medication changes or additions." I take it from your conversation with him and what he told you of his history, you thought there might be medical records from his time in the military?

A. Yes.

Q. And you would not have had easy access to those?

A. I had no idea how to get them, so I had a sense I didn't have easy access.

Q. All right. With other patients who perhaps have a military background, I guess was that your experience, you would ask them to obtain their records?

A. I'm not sure. I certainly have done that before, I can't remember every one as to what I did but some people volunteered their records. I remember someone once gave me a CD or DVD with 200 pages of notes on it.

Q. Okay. And just on that point, apart from what we might describe as military medical records if you wanted to obtain a patient's medical records in this set of circumstances from another province, what would you normally do to do that?

A. From a regular hospital, not military?

Q. Yes.

A. We would get the patient to sign a consent form and send it to the hospital's medical records department and ask them to send us x, y and z and they would always send it.

Q. Since this time, did you become any more familiar or did you find any easier route to accessing military records or have you had occasion to do that?

A. After this incident, we talked about the difficulty getting records and I understand that the then provincial director of mental health, Linda Khoury, talked to Veterans Affairs and I believe we were told that the best way to do it was to ask the veteran to go get the records themselves.

> Q. That's your understanding is still the process that's followed?
>
> A. Yes, I think I've seen something more recently that says you can phone a certain number but you still have to have the patient's consent so it still comes down to it's easiest just to have them call up and do it to get their records. And they also indicated that they don't have a record, as such, so I'm not sure what they actually send you but ...[204]

As described earlier, when Corporal Desmond and his wife attended at the clinic in Guysborough on October 13, 2016, and were seen by Dr. Harnish. The Desmond's were not able to provide a complete background on prior treatment. Dr Harnish was left to do an internet search for information on Ste. Anne's Hospital and OSI Clinic.[205]

Much of the evidence would suggest the obligation to obtain records as being left primarily with the patient. It needs to be noted that Corporal Desmond was psychologically and emotionally suffering and damaged during his periods of treatment. While the task of completing a permission form for disclosure may be termed menial by some, but for the suffering like Corporal Desmond it can become an almost impossible task.

Overarching the transfer of medical information and health practitioners reaching out to family for input are the legislative privacy requirement and professional ethics related to the same. Federally, Canada has two privacy acts covering how the Federal government and agencies handle personal information. *The Personal Information Protection and Electronics Documents Act,* s.c. 2000 c.5, deals with federally regulated business. More germane to the issues before the Inquiry is the *Privacy Act* which relates to access and collection, use and disclosure of personal

[204] Transcript – February 20, 2020 – Pages 99-101
[205] Transcript – March 10, 2021 – Pages 147-151

information. The CAF and VAC would be regulated by the provisions of the *Privacy Act*, 1980-81-82-83, c.111, Sch 11"1" Provincially personal information would be protected by privacy laws enacted by each and every provincial government.

Could VAC play a role in supporting veterans in obtaining and organizing their medical records? The Inquiry heard evidence regarding the structure and function of VAC. Lee Marshall, the Director of Corporate Affairs for Field Operations, explained that VAC pays for health care but does not provide direct health care. He explained that VAC is not the holder of a veteran's health records.[206] Mr. Marshall testified that VAC encourages veterans to ask for their medical file when releasing from the CAF. When asked if VAC could play a role in supporting veterans in this task, he said:

> Certainly, encouraging veterans to think about that and to access that information, extremely important. VAC may also support a veteran who, after the fact, wants to make a formal request to DND for access to their records. We may support them in that respect. In terms of physically getting involved in that process, I think there's a lot of discussion, debate, and analysis that would be required, and I'm not in a position to say whether we should or shouldn't do that.

While this Inquiry is limited in its ability to make recommendations related to federal government entities, there would seem to be value in VAC and the CAF being more pro-active in ensuring the serving members and veterans are able to easily access their medical records. This was pointed out previously in this report.

Veterans Affairs Canada recognized this issue and spoke to it in its file review, introduced as Exhibit P-000303[207] under a heading "Opportunities for Improvement." At page five, it suggests that prior to a veteran's relocation they should be provided information on local VAC office hours of operation and local resources. Also, it suggests a

[206] Transcript – April 20, 2021 – Pages 22-23, 151
[207] Exhibit – P-000303

timelier transfer of a veteran's file to a case manager following the veteran's relocation. As argued earlier in this report, a veteran should be provided a full copy of their medical records.

Even within the Province of Nova Scotia, we learned that records from different regions of the province and those held by private clinicians are not easily accessible. Records are kept in different electronic environments (including MEDITECH and OneContent) in different regions or zones with limited ability to interface. These electronic systems were described by Alyson Lamb, Interim Chief Nursing Informatics Officer, as "several quite old, non-integrated clinical systems."[208] The NSHA has embarked on a multi-year project, "One Person One Record," which is a collaboration of the Department of Health and Wellness, Nova Scotia Health and the IWK to have a single integrated health record for every Nova Scotian.

On February 1, 2023, the NSHA announced the Province had entered into a ten-year agreement with Oracle Cerner to design, build and maintain "One Person One Record."

However, even when that system is implemented, it will still be a record which incorporates health records from the Province of Nova Scotia only. Presently, if a person comes to Nova Scotia and has in their possession medical records from another province, they will need to provide them to a treating clinician or a medical records department at a hospital to be ingested (typically scanned or printed from another digital source and then scanned) into the databank.

[208] Transcript – March 12, 2021 – Page 15

Ms. Lamb explained that such records would then be categorized into an electronic category/file/basket referred to as "Historical Miscellaneous Documents."[209] Linda Plummer, the Director of Health Information Services for the NSHA provided a similar explanation, indicating that these records would be categorized as "External Documents Correspondence."[210] This is true of either the MEDITECH or One Content environments. The Inquiry was told that, technically, an electronic subcategory could be created in the medical records systems that could contain any medical information related to a veteran relocating to Nova Scotia from another province.[211] Additionally, it is something that could theoretically be done in the new One Person One Record environment, according to Ms. Lamb.[212]

24. Recommendation: That the Province of Nova Scotia liaise with other provinces and federal governments to improve the transfer of health records into each others record databanks.

Any further recommendation by the Judge about the foregoing matters.

Clearly implementation of recommendations will take time to occur. The One Patient One Record project described by Alyson Lamb is only coming to fruition at the time of this report. [213] Dr. Jaffe, who is no stranger to inquiries, recognized that "one of

[209] Transcript – March 12, 2021 – page 50
[210] Ibid – Page 114
[211] Ibid – Page 121
[212] Ibid – Page 72
[213] Transcript – March 21, 2021 – Page 15

the shortcomings with any inquiry is that when public attention is gone from these hearings, the impetus for change may diminish over time."[214]

The work that flows from this examination of the tragic deaths that occurred on January 3, 2017, will require significant work and collaboration over several government jurisdictions and departments. Dr. Jaffe made recommendations that the creation of a formal implementation committee with a five-year minimum time frame to accomplish these recommendations.

25. ***Recommendation: To ensure that the recommendations from this Inquiry are not lost in the passage of time, the Nova Scotia Government should create a formal implementation committee comprising of senior government officials from relevant departments to oversee the implementation of the inquiry's recommendation. This committee should have at minimum a five-year mandate and liaise with appropriate federal departments.***

[214] Exhibit – P-000334 – Page 35

Part IX

Acknowledgments and Conclusion

ACKNOWLEDGMENTS

Inquiries such as this involve a great deal of work by a number of people. The logistics of creating the framework and structure of this Inquiry and logistics of completing the Inquiry became much more apparent to me after working to complete the task of writing this report. It cannot be lost on the public that this Inquiry required fifty-six days of hearings that was broken up by a global pandemic. My role as writer of the Inquiry report is of small significance compared to those who contributed to the Inquiry before me.

First and foremost, I wish to acknowledge the pain and sorrow of those family members who lost their loved ones to the tragedy. Some were required to relive and endure more emotional trauma in lobbying for the Inquiry and having to relive their pain as witnesses. Additionally, they saw the Inquiry extended due to the pandemic and Judge Warren Zimmer being unable to complete the report.

I wish to acknowledge and underscore the work Judge Zimmer put into the Inquiry. His guidance and determination were evident in any conversation I had with Inquiry counsel and staff. He spent an inordinate amount of time and energy in travel to hearings, work outside the courtroom and having such an Inquiry weigh on his mind virtually 24/7.

Much credit has to go to Inquiry counsel, Allen Murray, K.C., and co-counsel Shane Russell who is now a Judge of the Provincial Court of Nova Scotia. As well, thanks to Judicial Assistants Selena Acker and Elise Levangie who, in addition to support to the court in Antigonish, served to be a major contributor to the administrative work of the Inquiry.

I would also like to thank Peter James, Kelly Burke, Janice Gillis and the Court Services team for setting up the initial off-site court space in Guysborough and then successfully transferring the operation to the Port Hawkesbury courthouse in the midst of a global pandemic.

Also, I would like to thank Spider Video for their support livestreaming the proceedings and the Executive office of the Nova Scotia Judiciary for Communications and IT support throughout the inquiry.

In relation to my work writing this report, and for her years as my Judicial Assistant, my heartfelt thanks to Lynne Weagle. Ms. Weagle retired weeks after me in the spring of 2023. She graciously agreed to come back part time to work with me on this report. Ms. Weagle was essential as she is one of the very few who can read my writing. Tammy Harnish, for her help with editing, and the entire staff at the Bridgewater Justice Centre gave assistance when needed and put up with me making almost daily use of office space.

I also wish to thank my wife Marilyn for her patience while I took on this report during what had been planned as the initial stage of my retirement.

I also stress that any deficiencies on areas that were left not fully covered in this report are due to myself and myself alone.

CONCLUSION

The overall purpose of this Inquiry, like so many others before it, is to examine the facts surrounding this tragedy and those that were similar. Then to make recommendations to the government that initiated it. The government is looking for potential recommendations that will inform policies in the hope that tragedy can be averted. The question is whether the Desmond family's tragic end could have been predicted or prevented. Dr. Scott Theriault and Dr. Peter Jaffe, both witnesses before this Inquiry touched on the predictive background to these facts.

Doctor Scott Theriault is the Clinical Director for the NSHA – Mental Health and Addiction Program in the Department of Psychiatry. His Curriculum Vitae is exceptional, and he is well known in all levels of court in Nova Scotia having been qualified as an expert in Forensic Psychiatry many times. He was commissioned by the Inquiry to complete a psychological autopsy on Corporal Desmond.

In his report Dr. Theriault states:

> An important aspect of managing this public health issue is the identification and management of suicide risk. The prediction of suicide, however, runs into the problem of the so-called "base rate problem." Given that suicide is, statistically speaking, a low probability event, any test attempting to assess suicide will, by its nature, have a high false positive rate, as the absolute risk of suicide is low. Hence, although there are a number of suicide risk assessment instruments available and assessment of suicide risk is an expected standard of care under Accreditation Canada, reliably predicting suicide is difficult.

He went on to say:

> Readers will note that throughout Mr. Desmond's course of care, he was periodically evaluated for suicide risk, which was generally felt to be low.

Dr. Jaffe is certainly one of the most authoritative experts on intimate partner violence in North America. He has written extensively on the subject including domestic homicides. At page eleven of his report Dr. Jaffe stated:

> Domestic homicides appear to be most predictable and preventable of all homicides. Friends, family, coworkers, and professionals who had contact with the victim and/or perpetrator often report warning signs that had concerned them. Often friends and family did not know what to do or say. They may have been hesitant to share their observations and worries. Frontline professionals may have lacked awareness or training about domestic violence warning signs. Many people wish they had taken action such as speaking to the victim or the perpetrator and encouraging them to get help. Some wished they had called the police or engaged the justice system much earlier for protection.

How do we reconcile these two statements? It would seem that both are dependant on observers of individual behaviour; and those treating individuals require that they have adequate information available to them. Much of the information regarding Corporal Desmond's mental health was retained by therapists and not readily available to others. Information contained in a silo assists no one outside of that silo. Indeed, the comments of Dr. Theriault and Dr. Jaffe are predicated on informational backgrounds being made available to health care professionals in a timely and fulsome manner.

In this Inquiry it was clear that the dissemination of information regarding Corporal Desmond was lacking among institutions, health care professionals and members of the community with concerns, but no real idea of where to go with these concerns, or even if they should.

Health care information needs to easily follow an individual across federal and provincial boundaries and within provinces. Individuals, professionals, and others need to take a close, hard look at the need to share concerns, and to work with those whose consent is needed to insure information flow.

It was striking that once Corporal Desmond transferred to Nova Scotia that it took many months to ramp up the care that Corporal Desmond needed. No one person should have a finger pointed at them. The issue was systematic. Up to and including the aftermath of January 3, 2017, Corporal Desmond was forward looking as far as therapy and counselling. We can only speculate as to what changed with that attitude just before Corporal Desmond walked into the Leaves and Limbs Sports and made his fateful purchase.

We know now that Corporal Desmond was not turned away from St. Martha's Hospital in the days leading up to the fatalities. We also know that crucial information regarding Corporal Desmond was not shared for many reasons.

Information flow is also crucial to Firearms Officers across the country to either grant a Possession and Acquisition Licence for a weapon or to place a PAL on review, and if need be, to have a firearm removed from an individual's possession. Individuals should take solace that these decisions regarding firearms are always reviewable.

It seems clear to this writer that several things are at the heart of what the Inquiry learned. Information should flow between professionals and others. Care needs to be taken by health clinicians when dealing with information to take proactive steps to ensure that all consequences are considered. Finally, we all owe a duty to our family, friends and neighbours to let others know if we find someone to be in trouble from either mental health or domestic partner violence.

At the end of the day, it is impossible to say with certainty that had the recommendations from this Inquiry been in place when Corporal Desmond left the

military no suicide or homicides would have occurred, but we can say that they possibly would have helped avert January 3, 2017.

REPORT OF THE INQUIRY

INTO THE DEATHS OF THE DESMOND FAMILY

VOLUME II

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Tab 1

Minister’s Order

IN THE MATTER OF
THE *FATALITY INVESTIGATIONS ACT*
S.N.S. 2001, c. 31

WHEREAS Aaliyah, Shanna, Brenda and Lionel Desmond (the "Desmonds") died on or about January 3, 2017.

AND WHEREAS the Chief Medical Examiner has investigated the Desmonds' deaths pursuant to the *Fatality Investigations Act* (the "Act");

AND WHEREAS the Chief Medical Examiner is of the view that the Desmonds' deaths occurred under circumstances referred to in clause 9(a) of the Act and that it is necessary that a fatality inquiry be held regarding their deaths;

AND WHEREAS the Chief Medical Examiner has, pursuant to Section 26 of the Act, recommended to the Minister of Justice that a fatality inquiry be held regarding the Desmonds' deaths;

IT IS ORDERED, pursuant to subsection 27(1) of the Act, that**:**

1. A fatality inquiry shall be held regarding the Desmonds' deaths.

2. The Chief Judge of the Provincial Court of Nova Scotia shall appoint a judge to conduct the inquiry in accordance with subsection 27(3) of the Act.

3. 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;

b. the cause of death;

c. the manner of death; and

d. the circumstances under which the death occurred including

(i) the circumstances of Lionel Desmond's release from St. Martha's Hospital on January 2, 2017;

(ii) whether Lionel Desmond had access to appropriate mental health services, including treatment for Occupational Stress Injuries;

(iii) whether Lionel Desmond and his family had access to appropriate domestic violence intervention services;

(iv) 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;

(v) given Nova Scotia administration of the Canadian Firearms Program, whether Lionel Desmond should have been able to retain, or obtain a licence, enabling him to obtain or purchase a firearm;

(vi) what restrictions, if any, applied to accessing federal health records of Lionel Desmond, by provincial health authorities or personnel; and

(vii) any recommendations of the judge about the foregoing matters.

DATED this 14th day of February 2018, at Halifax, in the Halifax Regional Municipality, Province of Nova Scotia.

____ ________________

Honourable Mark Furey
Minister of Justice and Attorney General

Tab 2

List of Counsel

List of Counsel

Alan Murray, K.C. and	Inquiry Counsel
Shane Russel – Now a Provincial Court Judge	Inquiry Counsel

Lori Ward

Counsel for the Attorney General of Canada

Melissa Grant

Co-counsel for the Attorney General of Canada

Glenn R. Anderson, KC

Counsel for the Attorney General of Nova Scotia

Catherine Lunn

Co- Counsel for the Attorney General of Nova Scotia

Thomas Macdonald

Counsel for Richard, Thelma & Sheldon Borden
and Co-counsel for Aaliyah Desmond

Roderick (Rory) Rogers, KC

Counsel for NS Health Authority

Karen Bennett-Clayton

Co- Counsel for NS Health Authority

Daniel J. MacKenzie

Co- Counsel for NS Health Authority

Martina Munden

Lesley Sawers

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Tara Miller, KC

Counsel for the Estate of Brenda Desmond
and Co-counsel for Aaliyah Desmond

Adam Rodgers
Counsel for the Estate of Lionel Desmond

Stewart Hayne
Counsel for Doctor Rahman and Doctor Slayter

Amy MacGregor
Co-Counsel for Doctor Rahman and Doctor Slayter

Tab 3

Rules of Procedure

Rules of Procedure

GENERAL

1. Subject to the *Act* and the Terms of Reference, the conduct of and procedure to be followed at the Inquiry are under the control of the Honourable Warren K. Zimmer, Judge of Provincial Court of Nova Scotia (the “Presiding Judge”).

2. All parties and their counsel shall be deemed to undertake to adhere to these Rules and may raise any issue of non-compliance with the Rules with the Presiding Judge.

3. Upon notice to the parties, these Rules may be amended from time to time or dispensed with by the Presiding Judge as he deems appropriate to ensure that the Inquiry is fair, thorough, and timely.

4. The Presiding Judge shall deal with a breach of these Rules as he deems appropriate including, but not restricted to, by revoking the standing of a party or by imposing restrictions on the further participation in or attendance at the proceedings by any party, counsel, individual or member of the media.

5. The Presiding Judge shall rule on any objections raised, determine all matters of procedure not provided for in these Rules and, when in his discretion it is necessary or desirable for the purposes of fully discharging the duties of the Inquiry, may allow departures from these Rules.

6. Pursuant to s. 29 of the *Act*, the Presiding Judge shall have the power to summons before him any persons or witnesses and to require them to give evidence and to produce such documents and things he deems appropriate.

DEFINITIONS

7. In these Rules

(i) "the *Act*" means the *Fatality Investigations Act,* S.N.S. 2001, c.31;

(ii) "document" is intended to have a broad meaning and includes the following: all records, files, audio recordings, audio-videotape recordings, communications, correspondence, notes, medical records, charts, data, memoranda, statements, reports, e-mail, text, cellular or social media messaging, digital reproductions, photographs, films, slides, maps, graphs, microfiche, metadata and any data and information recorded or stored by means of any device and any other information pertaining to the Inquiry, stored in any manner, including in written, electronic or digital form, irrespective of whether such document has been identified as confidential;

(iii) "party" means any person who has been granted full or partial standing at the Inquiry as an interested person or a personal representative pursuant to s. 36 of the *Act* and is not intended to convey notions of an adversarial proceeding;

(iv) "person" refers to individuals, groups, government agencies and departments, institutions, corporations or other entities;

(v) The terms "standing" and the "right to participate" are used synonymously in the Rules.

INQUIRY COUNSEL

8. Inquiry Counsel shall assist the Inquiry in the orderly conduct of the Inquiry and ensure that all relevant evidence is submitted to the Inquiry. Inquiry counsel shall have standing throughout the Inquiry.

PRE-INQUIRY INTERVIEWS AND INVESTIGATION

9. The Inquiry will commence with an investigation which shall consist of document review, consultation with interested persons and witness interviews.

10. Inquiry Counsel may request any person or any organization to submit to one or more interviews with Inquiry Counsel or other persons designated by Inquiry Counsel at reasonable times. No person or organization is required to submit to such interviews. Any audio recorded or audio-videotaped interview, any transcript of such interview or any summary of such interview is subject to disclosure to other participants at the Inquiry.

RIGHT TO PARTICIPATE

11. The Presiding Judge shall determine what persons shall be granted standing at the Inquiry, that is, what persons shall have the right to participate in the Inquiry proceedings and to be heard as interested persons and/or to be designated as a personal representative of the deceased, pursuant to s. 36 of the *Act*.

12. Persons who wish to be granted standing will be required to state in writing why they qualify for standing and how they propose to contribute to the Inquiry. Applicants for

standing will also be given an opportunity to appear in person before the Inquiry in order to explain why standing should be granted to them.

13. A person may be granted full or partial standing at the Inquiry and the Presiding Judge will determine on what terms and in which parts of the Inquiry a party may participate and the nature and extent of such participation.

14. The Presiding Judge may direct that a number of applicants share in a single grant of standing where he is satisfied the parties' interests are not adverse. In order to avoid duplication and to promote time and cost efficiencies, groups of similar interest are encouraged to seek joint standing.

15. The granting of standing at the Inquiry shall be contingent upon the parties' undertaking that they will abide by these Rules and, in particular, that they will comply with the Rules relating to the production of documents.

DOCUMENT PRODUCTION

16. All parties granted standing under these Rules shall produce to the Inquiry copies of all relevant documents in their possession or control having any bearing on the subject matter of the Inquiry by July 31, 2019. The obligation to produce all relevant documents is an ongoing and continuous one. Where a party discovers relevant documents subsequent to the initial disclosure, that party shall notify Inquiry Counsel immediately of the existence and nature of these documents and produce the documents to the Inquiry forthwith.

17. The term "relevant" is intended to have a broad meaning and includes anything that touches or concerns the subject matter of the Inquiry or that may directly or indirectly lead to other information that touches or concerns the subject matter of the Inquiry.

18. Documents shall be provided in the format directed by the Presiding Judge. Upon request, parties shall also provide originals of relevant documents in their possession or control. Unless otherwise requested, parties shall preserve originals of relevant documents until such time as the Presiding Judge has fulfilled his mandate or orders otherwise.

19. Parties granted standing may apply to Inquiry Counsel to require the production of any document and Inquiry Counsel may in his discretion require production of such document.

20. Where Inquiry Counsel refuses to require production of documents or present evidence, a party may apply to the Presiding Judge for an order requiring such production of documents or presentation of evidence. Such application must be made in writing, supported by an affidavit. If the Presiding Judge is satisfied that the production of documents or evidence is needed, Inquiry Counsel will seek production of the documents and present the evidence as requested. All parties shall be notified of any such application.

21. Where the Inquiry requires the production of any documents by any person either of its own motion, or as a result of an application, an Order to Produce may be issued by the Presiding Judge.

22. Any person served with an Order to Produce shall provide all requested information within that person's possession, control or power in the time indicated in the Order or, if no time is indicated, in a timely manner, and in the form directed by the Inquiry.

23. Where a party or person objects to the production of any document on the grounds of privilege, the document shall be produced in its unedited form to Inquiry Counsel who will review and determine the validity of the privilege claim. The party or person and/or their counsel may be present during the review process. Such a review shall not be deemed a waiver of the claim of privilege. In the event the party or person

disagrees with Inquiry Counsel's determination, the Presiding Judge, on application, may inspect the document and make a ruling on the claim of privilege.

24. Where a party or their counsel takes the position that any document that is produced to the Inquiry should be redacted before its disclosure to other parties, the party who wishes the redaction shall produce the document in its proposed redacted form. Inquiry Counsel will determine whether to accept the party's position that the document ought to be so redacted. If Inquiry Counsel is not prepared to recommend to the Presiding Judge that the document be so redacted, the party may apply to the Presiding Judge for a ruling on the redaction.

DISCLOSURE OF DOCUMENTS

25. Inquiry Counsel will disclose all documents in his possession, subject to necessary editing for confidentiality and relevance, to parties within a reasonable time prior to the proceedings or as directed by the Presiding Judge.

26. Counsel for parties will be provided with access to an electronic document database (the "Database") and other documents and information gathered or created by the Inquiry, including statements of anticipated evidence, only upon providing the Inquiry with a duly executed written undertaking in the form of Appendix "A" to these Rules. Where the Presiding Judge considers it appropriate, access to all such disclosure may be further restricted.

27. Counsel for parties shall not provide any person with access to the Database. Counsel may provide copies of documents and disclose information to their clients, witnesses or potential witnesses, and experts retained by them for the purposes of the Inquiry, as they deem appropriate, only on terms consistent with their undertakings and after they

have received from those individuals duly executed written undertakings in the form of Appendix “B” to these Rules.

28. Documents received from a party or any other organization or individual shall be treated as confidential by the Inquiry unless they are made part of the public record at the Inquiry or the Presiding Judge otherwise declares. This does not preclude the Inquiry from producing a document to a proposed witness prior to the witness giving their testimony or as part of the investigation.

29. All persons who have entered into a written undertaking pursuant to these Rules shall comply with the terms of their undertaking. Failure to do so is deemed to be a breach of an order of the Inquiry.

30. Counsel and parties are required to return to Inquiry Counsel all documents or witness summaries which are not produced in evidence, including those provided to clients, experts or other third parties, and to delete all electronic copies of documents and confirm such deletion.

OPEN HEARING OR IN CAMERA

31. Pursuant to s. 32 of the *Act*, the Inquiry proceedings shall be open to the public except where the Presiding Judge is of the opinion that (a) matters involving public security may be disclosed; or (b) intimate or personal matters or other matters may be disclosed at the hearing that are of such a nature, having regard to the circumstances, that the desirability of avoiding disclosure of the matters in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that hearings be open to the public.

32. If any party wishes any portion of the Inquiry proceedings to be held in-camera, they are required to make an application to the Presiding Judge for an order for that portion of the proceedings to be in-camera or an order prohibiting the disclosure, publication, communication of any testimony, document or evidence. Such applications shall be made in writing, supported by affidavit, at the earliest opportunity. The evidence and submission of such applications may be presented in private or in public, or a combination of both, at the discretion of the Presiding Judge.

33. If the proceedings are televised, streamed through the Internet or broadcast by some other medium, application may be made for an order that the evidence of a witness not be televised, streamed or broadcast.

EVIDENCE

34. The Presiding Judge may receive into evidence at the Inquiry any information that he considers relevant, appropriate and helpful in fulfilling the Inquiry's mandate, whether or not the information would be admissible in a court of law and may receive that information in any form that the Inquiry deems appropriate. The strict rules of evidence will not apply to determine the admissibility of evidence.

35. Without restricting the generality of the foregoing, the Inquiry may admit such written, oral or other evidence as the Inquiry in its discretion deems relevant, whether or not the admission of such evidence is in accordance with the normal rules of evidence.

36. The Presiding Judge may admit as evidence affidavits, statutory declarations or other evidence made or taken under the laws of Canada where the Inquiry considers it fit and proper to have such evidence presented whether such evidence is sworn or unsworn. The Presiding Judge may admit transcripts of related proceedings and

statements of individuals whether or not such individuals are available for examination and cross-examination.

37. Where possible the evidence of witnesses shall be taken under oath or solemn affirmation and witnesses shall be sworn or affirmed in the manner normally used in the Provincial Court of Nova Scotia.

38. All evidence taken in any manner provided for by these Rules of Procedure shall form part of the record of the proceedings of the Inquiry.

ACCESS TO INFORMATION

39. All documentary or physical evidence entered as exhibits at the Inquiry shall be identified and marked "P" for public hearings in numerical order and, if necessary, "IC" for in-camera hearings for which any non-disclosure, non-publication, or non-communication order has been issued in numerical order. The aforementioned marking scheme may be modified at the direction of the Presiding Judge.

40. Copies of the "P" transcript of the evidence of the public hearings and a "P" list of exhibits from the public hearings will be made available on the Inquiry website and for public review as soon as reasonably practicable.

41. Only those persons authorized by the Presiding Judge shall have access to the "IC" transcripts and exhibits.

WITNESSES

42. Where the Inquiry requires the attendance of any witness, either of its own motion or as a result of an application, a subpoena shall be issued and served on the witness.

43. Inquiry Counsel will call and question witnesses to testify at the Inquiry in accordance with s. 31 of the *Act*. Inquiry Counsel will provide each party with a proposed witness and exhibit list well in advance of the commencement of the Inquiry.

44. All parties are encouraged to provide Inquiry Counsel, at the earliest opportunity, the names and addresses of all witnesses whom they feel should be heard, together with a brief statement of the relevance of the witness to the Inquiry, as well as relevant evidence and copies of all relevant documentation.

45. Inquiry Counsel has the discretion to refuse to call a witness or present evidence. Where Inquiry Counsel refuses to call a witness or present evidence, a party may apply to the Presiding Judge for an order that such witness or such evidence be presented. Such application must be made in writing, supported by affidavit. It must indicate the name and address of the witness, give a summary of his or her anticipated testimony or the reasons for not providing it. If the Presiding Judge is satisfied that the witness or evidence is needed, Inquiry Counsel will call the witness or present the evidence. All parties to the Inquiry should be notified of any such application.

46. Inquiry Counsel shall proceed first with the examination of witnesses and may examine, cross-examine or re-examine all witnesses. Except as otherwise directed by the Presiding Judge, Inquiry Counsel can adduce evidence by way of both leading and non-leading questions. Other parties may, in such order as they have agreed or as directed by the Presiding Judge and, subject to such terms as may be imposed upon such right of examination by the Presiding Judge, cross-examine witnesses called by Inquiry Counsel, to the extent of their interest.

47. Counsel for a witness may apply to the Presiding Judge for permission to present that witness' evidence-in-chief. In that case, counsel will examine the witness in accordance with the normal rules governing the examination of one's own witness in court proceedings, unless otherwise directed by the Presiding Judge. Inquiry Counsel will then be entitled to examine the witness by way of both leading and non-leading questions. Other parties with standing will then be entitled to cross-examine the witness, to the extent of their interest and as provided in Rule 46.

48. Parties may suggest, in advance, lines of questioning to be put to witnesses by Inquiry Counsel.

49. Witnesses may be called to give evidence more than once.

50. Any party may apply to the Presiding Judge for an order excluding witnesses for any portion of the proceedings.

51. Witnesses who are not represented by counsel are entitled to have their own counsel present while they testify. Counsel for a witness will have standing for the purpose of that witness' testimony to make any objections thought appropriate and for other purposes set out in these Rules, including the right to cross-examine other witnesses if the Presiding Judge so directs.

52. In the ordinary course, witnesses will give their evidence at a hearing in person but in appropriate circumstances, as determined by the Presiding Judge, a witness may be permitted to give testimony via videoconference or teleconference.

EXPERT WITNESSES

53. The Inquiry may hear written or oral evidence from experts on topics relating to issues before the Inquiry, if the Presiding Judge believes it would be in the public interest to hear from someone with professional knowledge in particular subject areas. This evidence may include research, background or policy papers commissioned by or submitted to the Inquiry.

54. Inquiry Counsel will provide each party with the name, address, and qualifications of each proposed expert witness. This shall include any report which the proposed witness has prepared, as well as the area of expertise in which the opinion is being sought, and a summary of the anticipated evidence and copies of all relevant documentation.

PROCEDURAL MOTIONS

55. At any time, the Inquiry may hold Procedural Hearings for the purpose of determining what persons shall have the right to be heard as interested persons, for the purpose of having Inquiry Counsel tender documentary or other evidence which Inquiry Counsel determine should be tendered in advance of the public hearings for the convenience of the Inquiry or the parties, or to address any other procedural issue that may arise in the course of the Inquiry.

PRESENCE OF PARTIES

56. At the time and place appointed for holding the Inquiry, the Inquiry may proceed whether or not parties or their counsel are present.

SERVICE OF DOCUMENTS

57 Any notice, summons or other document issued under these Rules may be served personally at the address of the person to be served by certified mail, by e-mail or by facsimile to a party's legal counsel with acknowledgement of receipt or by such other method of service as the Presiding Judge may direct.

SUBMISSIONS BY COUNSEL AND PARTIES

58 When all evidence has been adduced, Inquiry Counsel and the parties shall have the right to address the Inquiry by way of oral and/or written submission in such order as the Presiding Judge directs and Inquiry Counsel shall have the right to address the Inquiry first and make the final submission to the Inquiry.

59 The Presiding Judge may direct that written submissions be made by Inquiry Counsel and parties in lieu of or in addition to their oral submissions.

ADJOURNMENTS

60 The Inquiry may adjourn its proceedings from time to time and from place to place.

CLARIFICATION OF RULES

61 These Rules are subject to clarification, amplification and amendment as the Presiding Judge deems appropriate to achieve the mandate of the Inquiry.

Tab 4

List of Experts

APPENDIX 4

List of Experts and Nature of the Opinion Evidence They Were Qualified by the Inquiry to Give

Dr. Matthew John Bowes, Chief Medical Examiner for the Province of Nova Scotia since 2006,

Dr. Erik K. Mont, Forensic Pathologist. Deputy-Chief Medical Examiner for the Nova Scotia Medical Examiner Service.

Dr. P. Scott Theriault, medical practitioner, licensed to practice psychiatry in Nova Scotia and New Brunswick. Retained to provide a psychological autopsy report.

Dr. Peter G. Jaffe, Licensed clinical and forensic psychologist. Expert in domestic violence and domestic homicide retained provide a report on domestic violence and domestic homicide.

Health Association of African Canadians – to inform on health issues concerning African Canadians, including education, research, health-care delivery and policy reform.

Tab 5

List of Witnesses

Desmond Fatality Inquiry
Witness List

DATE	NAME	
Jan 27-2020	Dr. Matthew John Bowes	
Jan 28-2020	Staff Sergeant Addie Maccallum	
	Sergeant Jennifer McNeil	
Jan 29-2020	Sergeant Jennifer McNeil (continuation of evidence)	
	Corporal Gerard Rose-Berthiaume	
	C/M Sean Hughes	
	C/M Gilles Marchand	
Jan 30-2020	Dr. Erik K. Mont	
Feb 03-2020	Dr. Justin Clark	
Feb 04-2020	Dr. Faisal Rahman	
Feb 05-2020	Dr. Faisal Rahman (continuation of evidence)	
Feb 10-2020	Dr. Ian Slayter	
	Heather Wheaton	
Feb 11-2020	Heather Wheaton (continuation of evidence)	
	Lee Anne Watts	
	Maggie MacDonald	
Feb 12-2020	Ellen Maureen MacDonald	
	Amy Mary Collins	
	Joan Hines	

Desmond Fatality Inquiry
Witness List

DATE	NAME
Feb 12-2020	Cathrine Elizabeth Chambers
Feb 13-2020	Cathrine Elizabeth Chambers (continuation of evidence)
Feb 18-2020	Constable Steven Richard
	Constable Burns Anderson
Feb 19-2020	Lysa Rossignol
Feb 20-2020	Lysa Rossignol (continuation of evidence)
	Derek Eardley
	Constable Leonard MacDonald
Feb 24-2020	Dr. Paul A. S. Smith
Feb 25-2020	Dr. Paul A. S. Smith (continuation of evidence)
	Nicole Mann
	Daniel Kulanek
Mar 02-2020	John Parkin
Feb 16-2021	Cassandra Desmond
Feb 17-2021	Paul Long
	Albert “Junior” MacLellan
	Chantel Victoria Ann Desmond
Feb 18-2021	Diane Marie Elizabeth Desmond

Desmond Fatality Inquiry
Witness List

DATE	NAME
Feb 18-2021	Corporal Orlando Trotter
	Katlin Michelle Desmond
Feb 19-2021	Sheldon Borden
Feb 23-2021	Dr. Vinod Joshi
Feb 24-2021	Dr. Wendy Rogers
Feb 25-2021	Dr. Mathieu Murgatroyd
Feb 26-2021	Dr. Anthony Njoku
Mar 2-2021	Dr. Robert Ouellette
Mar 3-2021	Dr. Isabelle Gagnon
Mar 4-2021	Kama Hamilton
Mar 5-2021	Julie Beauchesne
Mar 9-2021	Dr. Ranjini Mahendrarajah
	Natasha Tofflemire
Mar 10-2021	Dr. Ali Khakpour
	Dr. Luke Alexander Harnish
Mar 11-2021	Dr. Abraham (Rami) Rudnick
	Patrick Martin Daigle
Mar 12-2021	Alyson Lamb
	Linda Plummer

Desmond Fatality Inquiry
Witness List

DATE	NAME	
Mar 23-2021	Joe Roper	
Mar 24-2021	Julie Beauchesne	
	Maria Riccardi	
	Julie Blondin	
Mar 25-2021	Kenny Greencorn	
Apr 20-2021	Lee Marshall	
Apr 21-2021	Helen Luedee	
Apr 22-2021	Derek Leduc	
Jun 21-2021	Shonda Rochelle Borden	
Jun 22-2021	Marie-Paule Doucette	
Jun 23-2021	Marie-Paule Doucette (continuation of evidence)	
Sept 13-2021	John Parkin	
Sept 14-2021	Stephanie MacInnis-Langley	
Sept 15-2021	Nancy MacDonald	
Nov 01-2021	Dr. P. Scott Theriault	
Nov 02-2021	Dr. P. Scott Theriault (continuation of evidence)	
Nov 03-2021	Dr. Peter G. Jaffe	
Nov 04-2021	Dr. Peter G. Jaffe (continuation of evidence)	

Desmond Fatality Inquiry
Witness List

DATE	NAME	
Nov 29-2021	Health Association of African Canadians - Sharon Davis-Murdoch	
	- Lana MacLean	
	- Cynthia Jordan	
	- Robert Seymour Wright	
Nov 30-2021	Wayn Hamilton	
Mar 21-2022	Sharon Flanagan	
Mar 22-2022	John Parkin	

Tab 6

Inquiry Rulings

IN THE PROVINCIAL COURT OF NOVA SCOTIA

Desmond, (Re)

Re: An Inquiry under the ***Fatality Investigations Act***, S.N.S. 2001, c.31, as amended, into the deaths of Aaliyah Desmond, Brenda Desmond, Shanna Desmond and Lionel Desmond

Ruling on Application
for a Funding Recommendation by Cassandra Desmond,
the Personal Representative of Lionel Desmond

Judge:	The Honourable Judge Warren K. Zimmer
Heard:	May 23, 2019, in Guysborough, Nova Scotia
Decision:	June 13, 2019
Counsel:	Adam Rodgers, Esq., for the Applicant Glenn R. Anderson, QC., for the Respondent

By the Court:

[1] Cassandra Desmond, who is appearing as the personal representative of the deceased Cpl. Lionel Desmond, has made an Application requesting that I make a recommendation to the Department of Justice for a funding structure related to her legal costs to participate in the Desmond Inquiry. Mr. Adam Rodgers, Esq., appears on behalf of Ms. Desmond.

[2] It is argued that any recommendation should take into account three principal criteria including the effective representation of the personal representatives, the reasonable indemnification of legal costs and the protection of the public purse by retainer terms that are comparable to other private bar retainers in the province.

[3] The applicant takes the position that I have jurisdiction to make such a recommendation and that it is appropriate in the circumstances to do so.

[4] Mr. Glenn Anderson, Q.C., appears as counsel for the Attorney General of Nova Scotia. During oral argument on May 23, 2019, I asked Mr. Anderson whether or not there was any “real contest” to the issue of whether or not I could make a recommendation if I chose to exercise my discretion in that manner. He commented that, applying the case law from Alberta, it appeared that I may have

implicit authority to recommend funding, however, the issue was whether it extended to a funding structure and the position of the Attorney General was that it did not.

[5] In ***Alberta v Kamel*** [2002] A.J. No. 751, Mason J. on an application for judicial review relating to certain decisions of Judge D.M. MacDonald acting at a public fatality inquiry under the provincial ***Fatality Inquiries Act***, concerning orders relating to the payment of legal costs by the government, at paragraph [41] noted:

> **[41]** However, I do find that there is authority for a Provincial Judge appointed to conduct a fatality inquiry to recommend funding for legal counsel on a proper exercise of discretion. This would depend upon the nature of the inquiry; the issues to be decided; the parties involved; their respective entitlements to appear with legal counsel; the effect on other parties unable, for whatever reason, to appear with legal counsel; and the respective rights and responsibilities of the parties at risk arising out of the inquiry. There may well be other valid considerations to take into account, depending upon the matter to be investigated, the circumstances leading up to the inquiry, its conduct, and the likely results following its conclusion.

[6] The Alberta Court of Appeal in ***Alberta (Minister of Justice) v Bjorgan***, [2005] A.J. No. 1244, considered an appeal from a decision on judicial review that held a judge on a fatality inquiry did not have the authority to order that legal fees and disbursements be paid by the Crown and quashed the funding order. At paragraph 11 the court stated:

> **11.** We therefore conclude that the duty of procedural fairness cannot provide a fatality inquiry judge with the authority to mandate that funded legal counsel be provided to a target of the inquiry. While it maybe desirable to provide this authority to public inquiry commissioners in light of social policy considerations, such authority would have to be specifically provided for in the governing legislation. As it currently stands, a fatality inquiry judge has the authority only to: (1) recommend that an individual obtain legal counsel; (2) recommend that an individual apply for Legal Aid if unable to afford counsel; and (3) recommend that the Crown pay an individual's legal costs in those circumstances where it is considered necessary.

[7] Justice J.J. Gill in ***Martin Estate v Alberta,*** [2011] A.J. No. 1100, on an application for an order requiring the Crown to pay for a parties` legal fees on a fatality inquiry, considered an inquiry judge`s authority with regard to a recommendation. After referencing paragraph 11 from ***Bjorgan***, *supra*, the justice stated, in part:

> **18.** The Applicants submit that the Fatality Inquiry judge is powerless to act because all she can do is recommend that the Crown pay an individual's legal costs in those circumstances where it is considered necessary.

> **19.** In this case, the Applicants did not request that the Fatality Inquiry judge make such a recommendation. We do not know whether or not the Fatality Inquiry judge would have made such a recommendation if asked, nor do we know whether or not the Crown would pay the fees if the Fatality Inquiry judge were to make such a recommendation.

> **20.** What is important at this stage of the analysis, however, is to assess whether or not the Fatality Inquiry judge is powerless to act. Clearly, that is not the case. The Fatality Inquiry judge can make a recommendation to the Crown. Making recommendations is an essential component of a fatality inquiry judge's statutory jurisdiction under the *Act*: s. 53(2).

> **22.** The Provincial Court judge conducting a fatality inquiry is in the best position to determine the scope of the inquiry and whether or not a participant requires the assistance of legal counsel. In light of this fact and a fatality inquiry judge's broad powers over procedural matters, it is reasonable to assume that a fatality inquiry judge would recommend that the Crown pay an individual's legal costs if that judge thought it was necessary in the circumstances. Additionally, it is reasonable to assume that any such recommendation would carry some weight and be considered seriously by the Crown given the judge's unique position. If the Crown accepted the recommendation, funding would be provided.
>
> **23.** I conclude, therefore, that the Fatality Inquiry judge is not powerless to act and can assist participants who seek publicly funded legal counsel by making recommendations to the Crown where it is considered necessary. The power to make a recommendation is of significance. A participant who requires the assistance of legal counsel should formally request assistance from the fatality inquiry judge. The Applicants failed to do so in this case.

[8] In the present application, I am not being asked to make a general recommendation for funding but rather to recommend a specific hourly rate for counsel, the number of billable hours per day, no limitation on preparation time and an assessment process of the accounts by an independent lawyer.

[9] Mr. Anderson has filed his affidavit, to which he attaches as Exhibit 1 a copy of a letter dated May 1, 2019 to Mr. Rodgers, outlining the government's offer of funding assistance to the personal representatives. It reads in part:

> "I have authority to advise that the commitment of the Province to the personal representatives includes funding for counsel of their choice on the following basis:
>
> . . .

4. Counsel fees at a rate of $220 per hour;

5. Period for which fees are funded commences on January 1, 2019;

6. Maximum number of counsel hours per day is 9;

7. Maximum number of hours for preparation is 150. (Additional preparation time must be approved in advance);

8. Counsel disbursements, such as copying, travel, mileage, parking, meals and accommodation, are at government employee rates;

9. Counsel accounts (showing detailed time and attaching receipts) are subject to assessment and to be submitted monthly to an assigned official (separate from counsel)."

[10] Mr. Rodgers was in agreement with the funding commencement date of January 1, 2019, however, he suggested an hourly rate of $250 per hour. He recommended the maximum number of counsel hours per day at 10 and was agreeable with the specifications relating to counsel disbursements.

[11] With regard to counsel's accounts, he wanted them to be verified and approved by an independent lawyer either retained by the Inquiry itself for that purpose, or assigned by the provincial Department of Justice and fire-walled off from any lawyers acting in the Inquiry for the province, or alternatively, by a third-party lawyer retained by the province. He did not propose any limitation on preparation time.

[12] During his submissions, Mr. Rodgers in acknowledging that Justice Nunn recognized that limitations on preparation time were appropriate and that they could always be revisited as circumstances required, suggested that if there was going to be an initial limit on preparation time that it should be me and not the Department that reviews that number.

[13] In acknowledging that some assessment or review of the accounts was reasonable, he suggested a process whereby counsel submitted their accounts to the department, that is, to an independent lawyer within the department for review and if there was any dispute then the normal taxation route would be available. In his words: "That would, in some ways, Your Honour, eliminate the need to have a set cap on hours".

[14] At the hearing, Mr. Anderson was asked about a dispute resolution mechanism in the event the account reviewer and Mr. Rodgers could not come to some agreement and he advised that he did not have instructions to deal with that issue.

[15] In substance, I am being asked to make recommendations to the government, that relate to the spending of public funds, on issues that they have already addressed in their proposal to Mr. Rodgers.

[16] At the heart of this application lies a difference in the hourly rate offered by the government and requested by Mr. Rodgers in the amount of $30. The government has also committed 150 hours of preparation time with the caveat that additional hours are to be approved in advance. The parties do not seem to disagree on the need for some assessment of the accounts submitted, however, the government has no proposal for a review in the event any disputes cannot be resolved by agreement.

[17] The Supreme Court of Canada, in ***R v Cunningham,*** [2010] 1 SCR 331, in considering the inherent jurisdiction of superior courts, at paragraph 18, had this to say, at paragraph 19, regarding statutory courts:

> **19.** Likewise in the case of statutory courts, the authority to control the court's process and oversee the conduct of counsel is necessarily implied in the grant of power to function as a court of law. This Court has affirmed that courts can apply a "doctrine of jurisdiction by necessary implication" when determining the powers of a statutory tribunal:
>
> > ... the powers conferred by an enabling statute are construed to include not only those expressly granted but also, by implication, all powers which are practically necessary for the accomplishment of the object intended to be secured by the statutory regime …
> >
> > *(ATCO Gas and Pipelines Ltd. v. Alberta (Energy and Utilities Board),* 2006 SCC 4, [2006] 1 S.C.R. 140, at para. 51)
>
> At page 343:

> Although Bastarache J. was referring to an administrative tribunal, the same rule of jurisdiction, by necessary implication, would apply to statutory courts.

[18] In ***Ontario v Criminal Lawyers Association of Ontario,*** [2013] 3 SCR 3, (CLA) the Court at paragraph 66 noted that:

> …the experience with *Rowbotham* orders over the last two and a half decades has confirmed that an attitude of restraint, as, even in those *Charter* cases, courts have not considered it necessary to direct the rates to be paid to state-funded lawyers appointed to represent the accused.

[19] The Court referred to several appellate courts that had considered the issue and found it unnecessary to direct the rate of compensation. Reference was made to the case of ***R. v Chan***, 2002 ABCA 299 at paragraph 9 and 18:

> **9.** Courts are not the best qualified agencies to determine spending priorities for public funds: *Robinson, supra* at 487 (C.C.C.); *Rain*, supra at 192 (C.C.C.). Courts do not set, nor are they asked to set, elevated fees for doctors or other professionals such as nurses, accountants, or midwives. Courts do not set health care premiums, levels of taxation, sessional indemnities or jury fees.
>
> **18.** Paragraph 65 found that the $150 per hour which the court imposed on the Crown would be "better suited" to this prosecution than would something unstated. But that is not the test. One can always find resources, persons, or means of higher quality. The "best around" is emphatically not the test. All that is required is a level of legal representation which ensures that the accused's answer to the allegations of his guilt is made available to the adjudicating court. Certainly not matchless Nobel-level privately retained representation.

[20] CLA was a decision that dealt with a number of cases before the court in which the trial judges had appointed *amicus* and thereafter had determined rates

and mode of payment that the Attorney General was required to pay. The court stated:

> **75.** In those exceptional cases where *Charter* rights are not at stake but the judge must have help to do justice and appoints an *amicus*, the person appointed and the Attorney General should meet to set rates and mode of payment. The judge may be consulted, but should not make orders regarding payment that the Attorney General would have no choice but to obey.
>
> **80.** In summary, the ability to fix rates of compensation is not necessary for the court to make its power to appoint *amici curiae* effective, and the judicial process will not be weakened or imperilled if compensation cannot be ordered. Indeed, even following a *Rowbotham* application, when the courts have the jurisdiction to direct compensation for counsel appointed under s. 24(1) of the *Charter*, [page36] the courts have rarely found it necessary to direct the rates payable to defence counsel.
>
> **81.** Allowing superior and statutory court judges to direct an Attorney General as to how to expend funds on the administration of justice, in the absence of a constitutional challenge or statutory authority, is incompatible with the different roles, responsibilities and institutional capacities assigned to trial judges, legislators and the executive in our parliamentary democracy.
>
> **82.** In the end, what concerned the Court of Appeal was the proper course to follow if the Attorney General is unreasonable and a particular lawyer is not prepared to accept the rates for service as *amicus*. While trial judges have a number of options regarding how to proceed in the face of such an impasse, they do not have the power to determine what a reasonable fee is or to order the government to pay it. Such orders cross an impermissible line. The other pillars of government are accountable for establishing spending priorities and, so long as their initiatives pass constitutional muster, have the institutional capacity to define public policy and find program solutions. The Court must allow provinces the flexibility they require to meet their constitutional obligation to fund *amici*, when essential.
>
> **83.** While the rule of law requires an effective justice system with independent and impartial decision makers, it does not exist independently of financial constraints and the financial choices of the executive and legislature. Furthermore, in our system of parliamentary democracy, an inherent and inalienable right to fix

> a trial participant's compensation oversteps the responsibilities of the judiciary and blurs the roles and public accountability of the three separate branches of [page37] government. In my view, such a state of affairs would imperil the judicial process; judicial orders fixing the expenditures of public funds put public confidence in the judiciary at risk.
>
> **84.** For the reasons stated above, the ability to set rates of compensation for *amici* does not form part of the inherent jurisdiction of a superior court. Given this conclusion, it follows that the ability to set rates of compensation for *amici* does not form part of the implicit powers of a statutory court to function as a court of law.

[21] I am satisfied that I have jurisdiction to make a recommendation for funding in appropriate circumstances. A funding scheme has been proposed by the government, however, it is not acceptable to Mr. Rodgers who asks me to make more specific recommendations that relate directly to the expenditure of public funds. In my view, part of what Mr. Rodgers is asking me to do at this time oversteps my judicial authority and I decline to recommend a particular hourly rate or the number a billable hours in a day or preparation time limits.

[22] I accept that I can be consulted and in this regard would suggest that the parties meet to discuss a dispute resolution mechanism to deal with unresolvable billing issues. The taxation procedure in the ***Small Claims Court Act*** is particularly suited to that purpose.

[23] I would observe that the government has already made a decision and commitment to provide funding to the personal representatives of the deceased for the Inquiry. That, in itself, is a recognition of the importance of having them present and participate in the inquiry process with a view to assisting in achieving the mandate of the Inquiry. It would be strange indeed if the government, partway through the Inquiry determined that no additional preparation time was to be permitted, and, thereby, effectively eliminate counsel from further participation except on a *pro bono* basis which in my view would be unreasonable. The only limitation in the offer is that additional preparation time must be approved in advance and that is not unreasonable given the commitment of the province.

[24] The Application is dismissed.

Zimmer, JPC

IN THE PROVINCIAL COURT OF NOVA SCOTIA

Desmond, (Re)

Re: An Inquiry under the ***Fatality Investigations Act***, S.N.S. 2001, c.31, as amended, into the deaths of Aaliyah Desmond, Brenda Desmond, Shanna Desmond and Lionel Desmond

DECISION
PARTICIPATION APPLICATIONS

Judge: The Honourable Judge Warren K. Zimmer

Heard: May 21, 2019, in Guysborough, Nova Scotia

Decision: June 20, 2019

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

By the Court:

[1] On May 21, 2019, the Desmond Inquiry began and Applications to Participate at the fatality inquiry pursuant to Section 36 of the *Fatality Investigations Act* were heard.

[2] Section 36(1) of the *Fatality Investigations Act* provides that a Crown attorney or counsel for the Minister shall appear at a fatality inquiry and may examine and cross-examine witnesses and present arguments and submissions. Mr. Allen Murray, QC, Chief Crown Attorney, Central Region and Shane Russell, Senior Crown Counsel have both been designated to appear at the Inquiry and, accordingly, they have the right to participate and will act as Inquiry Counsel.

Richard Borden and Thelma Borden

[3] Section 36(2)(a) of the *Fatality Investigations Act* directs that a personal representative of the deceased is a participant at a fatality inquiry. Richard and Thelma Borden have jointly come forward as the personal representative of their daughter Shanna Desmond, who is a deceased, and, accordingly, they are entitled to participate at this Inquiry. Their counsel is Coline Morrow.

Sheldon Borden

[4] Sheldon Borden has made an Application to Participate at this Inquiry as an interested person. He is the brother of Shanna Desmond, brother-in-law of Lionel Desmond and uncle of Aaliyah Desmond. He has a clear and substantial connection to the mandate of the Inquiry and will be permitted to participate.

Chantel Desmond

[5] Chantel Desmond is the daughter of Brenda Desmond and has made an Application to Participate at the Inquiry as the personal representative of Brenda Desmond, a deceased. Accordingly, she will be entitled to participate at this Inquiry. Her counsel is Tara Miller, QC.

Cassandra Desmond

[6] Cassandra Desmond is the brother of Cpl. Lionel Desmond, a deceased, and she has made an Application to Participate at the Inquiry as his personal representative. Ms. Desmond will be entitled to participate at this Inquiry in that capacity. Her counsel is Mr. Adam Rodgers.

Attorney General of Canada

[7] An Application was received from the Attorney General of Canada seeking standing as a party to the Inquiry. I understand that Lionel Desmond, as a member of the Canadian Armed Forces, and later as a veteran, interacted with various federal entities while accessing federally supported services and benefits and that various government agencies would have information relating to the Inquiry's mandate. It is clear that the participation of the Attorney General would assist in advancing the Inquiry's investigation, accordingly, participation rights are granted. Ms. Lori Rasmussen and Ms. Melissa Grant are counsel.

Attorney General of Nova Scotia

[8] The Attorney General of Nova Scotia, representing Her Majesty the Queen in Right of the Province of Nova Scotia has applied to participate in the Inquiry on behalf of all of Nova Scotia's departments, agencies, and officials who have relevant information to provide to the Inquiry within the Terms of Reference of the Minister's Order. There are a number of provincial departments, agencies and officials who possess documents and knowledge relevant to the terms of the Inquiry. It is clear the province would have a direct interest in the subject matter of this Inquiry and any recommendations that may be forthcoming. The Attorney

General will be granted the right to participate. Mr. Glenn R. Anderson, QC, is counsel.

Nova Scotia Health Authority

[9] An Application to Participate has been received from the Nova Scotia Health Authority. The Nova Scotia Health Authority operates hospitals and health centres in the Province of Nova Scotia including St. Martha's Regional Hospital in Antigonish and the Guysborough Memorial Hospital in Guysborough, Nova Scotia. The Nova Scotia Health Authority has various records relating to assessment, treatment and care of Mr. Desmond at these facilities that would be relevant to the subject matter of the Inquiry and its scope as set out in the Minister's Order. In addition to the records, there are the Health Authority employees who interacted with Mr. Desmond at various relevant times who can likely assist the investigation. The Nova Scotia Health Authority will be granted standing to participate. Mr. Roderick (Rory) H. Rogers, QC, and Ms. Karen N. Bennett-Clayton are outside counsel. Ms. Martina Munden and Ms. Lesley Sawers are in-house counsel.

Dr. Ian Slayter

[10] Dr. Slayter is a psychiatrist who provided mental health services to Lionel Desmond in 2016 and proximate to the events of January 3, 2017. Given the Terms of Reference his participation would appear to be highly relevant. His application to participate is granted. His counsel is Mr. Stewart Hayne.

Dr. Faisal Rahman

[11] Dr. Rahman has made an Application to Participate and I am granting his application. Dr. Rahman has relevant and important information relating to Lionel Desmond who he saw at St. Martha's Regional Hospital on January 2, 2017. His counsel is Mr. Stewart Hayne.

(Sgt. Retired) David T. MacLeod

[12] Retired Sgt. David MacLeod filed an Application to Participate in the Inquiry seeking to make an opening statement as well as a closing submission. Mr. MacLeod had the opportunity to address the Inquiry on May 21, 2019. With regard to making a closing submission, if he intends to file a written submission following the evidence, and relating thereto, then he is permitted to do so. If he

wishes to make an oral closing submission, I would ask him to contact Mr. Murray at the close of the evidence for further clarification.

Heather MacPherson

[13] Heather MacPherson also filed an Application to Participate in the Inquiry. Ms. MacPherson appeared on May 21, 2019 and addressed the Inquiry and, in particular, related circumstances concerning her father, his service to our country and the difficulties that he encountered following his service. I would like to thank her for taking the time to complete the Application and appear before the Inquiry to provide her personal insight the importance of which is not lost sight of.

Zimmer, JPC

IN THE PROVINCIAL COURT OF NOVA SCOTIA

Desmond, (Re)

Re: An Inquiry under the ***Fatality Investigations Act,*** S.N.S. 2001, c. 31, as amended, into the death of Aaliyah Desmond, Brenda Desmond, Shanna Desmond and Lionel Desmond

DECISION
INFORMAL REVIEW

Judge:	The Honourable Judge Warren K. Zimmer
Heard:	June 21, 2021, in Port Hawkesbury, Nova Scotia
Counsel:	Allen Murray, QC, Inquiry Counsel Shane Russell, Esq., Inquiry Counsel

By the Court:

[1] This is my decision with regard to the release referred to as Veterans Affairs Canada, the VAC informal review.

[2] On April 20th, 2021, we had a discussion following the evidence that day relating to some documentation that had been provided to the Inquiry by counsel for the Attorney General of Canada.

[3] By way of a brief summary, on April 11th, 2021, Ms. Grant had sent an e-mail to Inquiry Counsel with some notes that had been prepared by Marie-Paule Doucette which had, apparently, been utilized as part of an informal file review conducted by Veterans Affairs Canada. The review is of the information that was documented into VAC's electronic data base called Client Service Directory Network [CSDN].

[4] The informal review document was not provided to Inquiry Counsel at that time as counsel for the Attorney General of Canada took the position that the report was protected by jurisdictional immunity and was outside the Terms of Reference of the Inquiry. Counsel did provide a copy of the informal report to Inquiry Counsel to allow me to review it and make a determination as to whether

or not it should be disclosed with or without redactions prior to disclosure. I understand counsel does not wish to make any further representations on the issue beyond what was earlier stated.

[5] I note that in the e-mail to Inquiry Counsel from Ms. Grant there was the following comment:

> While we appreciate the results of any review conducted by CAF or VAC could be of some assistance to the Inquiry, both the review and results are beyond the terms of reference and will not be provided.

[6] The Rules of Procedure for the Desmond Inquiry include a provision relating to relevant document production. Paragraph 17 of the Rule states:

> 17. The term "relevant" is intended to have a broad meaning and includes anything that touches or concerns the subject matter of the Inquiry or that may directly or indirectly lead to other information that touches or concerns the subject matter of the Inquiry.

[7] The Order of the Minister directing this Fatality Inquiry at paragraph 3(d)(ii) reads in part:

> 3. 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:
>
> d. the circumstances under which the death occurred including
>
> (ii) whether Lionel Desmond has access to appropriate mental health services, including treatment for Occupational Stress Injuries;

[8] Ms. Cassandra Desmond testified at this Inquiry, and through counsel, provided some of the e-mail correspondence that she had with Dr Alexandra Heber, Chief Psychiatry, Veterans Affairs Canada. By e-mail from Dr. Heber dated October 31st, 2017, the doctor wrote in part:

> We would like to meet with you as part of a medical suicide review that we have been asked to do by Veterans Affairs Canada. The purpose of our meeting will be to get your perspective and thoughts, as we identify areas for improvement in the support of Veterans. We are very interested to hear what you and your family have to tell us.

[9] Later in an e-mail dated December 23rd, 2017, Dr. Heber said in part:

> I have read the recent reports that the Nova Scotia medical examiner may call an inquiry. I hope that if this happens, you and your family will get answers to many of the questions.

[10] I have read the informal report and in my view it meets the test of relevancy, and with regard to the issue of jurisdictional immunity raised by Ms. Ward, as I said in my opening remarks on May 21, 2019 at page 15:

> This Inquiry must also keep in mind the fact that it has limited authority to inquire into areas of federal jurisdiction.
>
> In ***Re Rogers,*** [2017] AJ No 1079, Prov Ct Judge Richardson made a number of observations during a Fatality Inquiry, under the Alberta ***Fatalities Inquiries Act,*** in relation to this limitation. I borrow from her decision as follows, to give an overview of the issues:
>
>> **17.** Appellate courts have repeatedly pronounced that the constitutional jurisdiction for the Fatality Inquiries Act is derived from the assignment of the "administration of justice" to the provinces in s. 92(14) of the *Constitution Act.*

18. The Canadian Forces is a federal entity. The doctrine of paramountcy precludes any provincial statutory authority over a federally created or regulated body. The issue of the jurisdiction of a fatality inquiry over a federally regulated activity was the subject matter of *Mercier v. Alberta (Attorney General)*, 1997 ABCA 161. In that case, the Court found that a "fatality inquiry will be permissible if it does not intrude heavily on the core of the federal subject by regulating aviation accidents or investigating the management of the executive branch of the federal government" (para 13).

19. The Court of Appeal went on to direct the application of the dominant purpose principle to determine the jurisdiction of the scope of the fatality inquiry. Citing *Faber v. The Queen* [1976] 2 S.C.R. 9 from the Supreme Court, the Court of Appeal said "[Fatality inquiries are] to assist and reassure the public by exposing the circumstances of a death. An inquiry dulls speculation, makes us aware of the circumstances which put human life at risk and reassures all of us that public authorities are taking appropriate measures to protect human life" (*Mercier,* para 14).

20. The intersection of provincial authority over the administration of justice and the death of someone within a federal entity or federally regulated activity has attracted appellate consideration. In *Quebec (Attorney General) and Keable v. Canada (Attorney General) et al.,* 1978 CanLII 23 (SCC), Justice Pigeon held that no provincial authority could intrude into the management, regulation and practices of the RCMP, a federal agency. The Supreme Court in *Canadian National Railway Co. v. Courtois,* 1988 CanLII 82 (SCC) at para 24 interpreted *Keable* as standing for the proposition that "provincial commissions of inquiry…cannot be empowered by a province to investigate a federal institution…its services, rules, policies and procedure so as to make recommendations on changes to be made to those rules and methods" (para 24).

21. The appellate authority is clear that a provincial inquiry cannot become a *de facto* review into the organization, management, policies, procedures, practices or regulations of the Canadian Forces. The scope of this inquiry cannot be [that] broad…

In ***Keable*** the Court noted that when an inquiry into a matter that is within provincial competence reveals the desirability of changes in federal law, that the inquiry could "submit a report in which it appeared that changes in federal laws would be desirable". This did not mean that the gathering of information for the

> purpose of making such a report may be a proper subject of inquiry by a provincial inquiry. The inquiry cannot be indirectly that which it is prohibited from doing directly, as that would engage the doctrine of "colourability".

[11] I read the informal review carefully and in my view disclosing it in the context of this fatality inquiry does not intrude upon federal jurisdiction. It does not intrude heavily into the federal areas and it does serve to reassure the public, that in this case, Veterans Affairs Canada are taking appropriate measures to protect human life.

[12] The informal review, in my view, is properly subject to disclosure and to be made available to counsel and will be released later today.

Zimmer, JPC

IN THE PROVINCIAL COURT OF NOVA SCOTIA

Desmond, (Re)

Re: An Inquiry under the ***Fatality Investigations Act,*** S.N.S. 2001, c. 31, as amended, into the death of Aaliyah Desmond, Brenda Desmond, Shanna Desmond and Lionel Desmond

DECISION

RULING ON STANDING

Judge:	The Honourable Judge Warren K. Zimmer
Heard:	October 13, 2021, in Port Hawkesbury, Nova Scotia
Decision:	March 31, 2022
Counsel:	Allen Murray, QC, Inquiry Counsel Shane Russell, Esq., Inquiry Counsel

By the Court:

[1] On May 21, 2019, the Desmond Inquiry began and Applications to Participate at the fatality inquiry pursuant to section 36 of the ***Fatality Investigations Act*** (the Act) were heard.

[2] Section 36(2)(a) of the Act provides that "any person who applies to the judge before or during the inquiry and is declared by the judge to be an interested person" may be a participant.

[3] On October 13, 2021, the Inquiry heard applications from the Health Association of African Canadians, Nick Cardone, Derek Hill, Raymond Sheppard and May Machoun.

[4] The Health Association of African Canadians, following their application and further discussions, were permitted to participate by filing a brief in advance of a panel presentation of evidence before the Inquiry.

[5] Mr. Raymond Sheppard`s application included reading a prepared statement to the Inquiry and did not seek to participate beyond that statement.

[6] Mr. Nick Cardone is a therapist in private practice in Nova Scotia registered with the Nova Scotia College of Counselling Therapists. He has a private practice

called Free Range Therapy where he does, primarily, individual counselling with male-identified teenagers or adults under the auspices of mental health and addictions. He also co-facilitates a project called T.O.N.E., which stands for Therapy Outside Normal Environments, which is a group therapy alternative for adult men who are struggling with mental health and addictions.

[7] Mr. Cardone is also involved in other therapy services that are oriented to male-identified individuals in settings outside of those traditionally associated with mental health and addictions counselling.

[8] Mr. Cardone`s approach and philosophy to therapy is noted, however, I do not see it as furthering the conduct of the Inquiry as set out in the terms of reference.

[9] Mr. Derek Hill also made an application to participate in the Inquiry. In his opening statement he explained that the root cause of the "horrible tragedy" was twofold. The first cause related to:

> … the obviously illegal negligent and fraudulent invocation of Article 5 of the NATO Treaty on September 12th, 2001. … Article 5 was invoked just one day after 9/11 by a NATO official who, according to their own reporting, was still in a state of shock, confusion, and ignorance of the facts relating to the horrible 9/11 attack just one day earlier.

[10] I explained to Mr. Hill that the broader geopolitical circumstances under which the war in Afghanistan came about, or how it was that Lionel Desmond wound up in Afghanistan and exposed to the traumas of war that likely resulted in post-traumatic stress disorder and likely major depressive illness and other issues that invaded his life, were beyond the scope of what I could look at and consider under the legislation creating the fatality inquiry.

[11] It was Mr. Hill's position that the root cause of the death (Cpl. Desmond) was:

> ***The undemocratic, negligent and shortsighted*** [*sic*] ***way that just a few of our politicians and tricky NATO bureaucrats sent our precious troops into Afghanistan combat and kept them there for much, much too long.***

[12] His recommendation to avoid such circumstances in the future was to:

> ***Legislate exclusive authority for sending our troops into combat to be in the hands of the Canadian citizens, writ large, by way of national public referendum.***

[13] Mr. Hill`s submissions do not address the terms of reference of the Inquiry.

[14] May Machoun made an application to participate and presented the Inquiry with extensive material that was well researched.

[15] She retired from the military with over 29 years of military medical experiences gained primarily as a result of being a military medical technician. She was a civilian primary care paramedic for over 10 years as well as being a military trained physician assistant. She has had first-hand experience with brain injury, a diagnosis of post-traumatic stress disorder and has gone through the process of release through the military. She was a military physician assistant with the rank of captain at the time of her release April 17, 2020.

[16] Ms. Machoun in her submissions makes it clear to me that much of her experiences relate to her time and interactions with a variety of federal entities that Cpl. Desmond was also engaged with leading up to and post release. Although I believe she appreciates that the Inquiry does have limited jurisdiction to deal with and make recommendations concerning Department of National Defence and Veterans Affairs Canada policies, much of the information provided relates to practices, training and policies within the Canadian Armed Forces healthcare system.

[17] The challenges that she faced in dealing with the Canadian Armed Forces, as described in her supporting documents, were considerable. However, the jurisdictional limitations that this Inquiry has simply do not give me sufficient leeway to hear from her and of her personal journey as important as it may be.

[18] Thank you for your service Ms. Machoun.

Zimmer, JPC

Tab 7

Medical Reports

Health Association
of African Canadians
Our Health is our Wealth

The Desmond Inquiry

Lack of Apppropirate Mental Health and Domestic Violence Services to Black Nova Scotians as a Contributing Factor

Sharon Davis-Murdoch, Co-President, Health Association of African Canadians
Robert S. Wright, Executive Director, The Peoples' Counselling Clinic
Lana M. MacLean, Mental and Emotional Support Counsellor
Cynthia Jordan, Mental and Emotional Support Counsellor

Health Association
of African Canadians
Our Health is our Wealth

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Background

The Health Association of African Canadians (HAAC) is a non-profit health association based in Dartmouth, Nova Scotia. Established in 2000, our mandate is to inform health issues concerning African Canadians. These include education, research, health-care delivery, and policy reform.

The HAAC Vision is: Thriving, healthy African Canadian Communities in Nova Scotia and the Mission is to: promote and improve the health of African Canadians in Nova Scotia through community engagement, education, policy recommendations, partnerships, and research participation.

Our work as Black health advocates for twenty-one years, has made us acutely aware of the lack of culturally specific mental health and domestic violence services in Nova Scotia. We understand this at the same time as understanding the disproportionate impact of the combined social determinants of health of our populations including the inextricably linked determinant of Anti-Black racism.

It is recognized that systemic racism impacts all aspects of service delivery in Nova Scotia as highlighted in the highlighted in the ground-breaking 1990 Marshall Inquiry and later in the 1994 Black Learners Advisory Committee (BLAC)Report on Education: Redressing Inequity-Empowering Black Learners.

In working with People of African Ancestry about their experiences navigating the healthcare system in Nova Scotia, the inability to access informed and culturally specific health resources and culturally competent care is a recurring reality. An overall mistrust of the healthcare system, stemming from decades of institutional Anti-Black racism, micro-aggressions, and overt forms of discrimination, has led many Black Community members to feel that their voices or concerns are not heard or understood by a health care system that does not reflect them or respond to their needs. As we write today, in the year 2021, health data is not available by race, ethnicity or language, we rarely see ourselves reflected in health messaging, we do not have representation on the Nova Scotia Health Board and far too few of us work as clinicians within the health professions, are in executive leadership roles or lead health research.

Perhaps the least robust area of health care with respect to culturally specific approached is mental health (including support for victims and perpetrators of domestic violence).

In 2012 the *Nova Scotia Mental Health and Addictions Strategy: Together We Can* identified that generations of racialized people including African Nova Scotians had not been "served sufficiently" by the mental health and addiction care system. In 2016 Mental Health Commission of Canada identified barriers to seeking mental health support. These included among others, service accessibility and provider-patient interaction (suggesting a lack of culturally competence and clinical cultural competence).

Though a project was established to help fill gaps in mental health service delivery to racialized people as a result of the provincial Strategy there was incomplete development of a curriculum that would begin to improve service providers' knowledge with respect to the needs and lived reality of African Nova Scotian People.

A network of Black mental health workers was built from this work and still exists. The support of these individuals and the expansion of the network is key to improving mental health outcomes for People of African Ancestry living in Nova Scotia.

Mental Health and Addictions: What's Been Done & Considerations for What Is Needed

In 2017 and 2018, the Health Association of African Canadians[1] in partnership with the African Canadian Services Division[2] (NS Dept. of Education) hired Lana M. MacLean & Associates (Contractor) to provide culturally responsive psychoeducation session to under serviced African Nova Scotian[3] communities with a primary focus on rural communities.

Using a community development and engagement lens, the Contractor reached out to the Black Educators of Nova Scotia, Regional Educators, the African United Baptist Association[4] , Social Justice Committee, Provincial Baptist Youth Fellowship leadership and members of the AUBA clergy and Student support workers in various jurisdictions to recruit members of the community to participate in a full day workshop called, *Mental Health 101- The Black Experience.*

The format of the Mental Health 101 Workshop consisted of but not limited to:

1. A Full day of psychoeducation with experiential learning through role play on issues identified by participants
2. Providing an awareness of the difference between mental health and mental wellness
3. Providing base knowledge on prevalent mental health diagnoses such as: anxiety, depression, race-based trauma, addiction and post-traumatic stress disorder, ADHD and dementia. All of the topics explored were generated by workshop participants and community leaders.
4. Wellness plans; and
5. Creating a local list of resources for accessing mental health and addiction care

The request of the community was to provide the Mental Health 101 sessions in each of the Black Communities in the province. In 2017, sessions were held in: North End Dartmouth, the Preston Township, North End Halifax, Central Halifax, Yarmouth and Digby area, Bridgewater, Kentville, Sydney, Truro, Amherst, New Glasgow, Guysborough Sunnyvale and Sydney/Glace Bay.

Over, 100 members of the ANS community attended the sessions offered across the province.

Guysborough - African Nova Scotian Communities Lens

With the success of the 2017 program; in 2018, community members from the Antigonish Guysborough communities of Sunnyville, Lincolnville and Upper Big Tracadie requested follow up session. Follow up sessions were also requested in the Bridgewater, Yarmouth and Valley regions noting similar mental

[1] www.haac.ca
[2] www.ednet.ns.ca/acs/
[3] African Nova Scotian in this report may be abbreviated and or referenced as -ANS
[4] www.aubans.ca

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health and addiction issues. The above notes demonstrate there is a significant need and openness within ANS communities to engage in culturally relevant and responsive mental health and addiction programs.

Various modalities were used to engage workshop partisans including videos, direct teaching, role play, mindfulness and therapeutic art. All modalities integrated a cultural lens to reflect the racial and cultural needs of the community.

Many elders and leadership of these historical ANS communities identified the need for ongoing culturally relevant learning opportunities targeted toward the mental health and addiction education and treatment. The area of needs identified included, but not limited to, anxiety, depression, dementia, inter partner violence, substance use, and intergenerational trauma.

Facilitators also identified areas a significant deficit in terms of understanding the impacts of systematic racism and generational trauma. Such deficits and ongoing frustration with experiencing microaggressions and systematic barriers to health, education and employment often manifests in unhealthy coping and internalized negative self-worth. Such experiences are often exhibited in unhealthy defense mechanisms such as the following: regression (staying in bed when depressed), dissociation ((loses track of time and/or sense of self), acting out (yelling, arguing), denial (not acknowledging a problem with metal health or addiction out of fear), projection (blaming others), displacement (redirecting thoughts, feelings towards someone not related to the point of frustration), to name a few.

Members of the African Nova Scotian Community presenting with severe concurrent disorders (addiction and mental health) who have developed such defenses over decades of mistrust and negative experiences within government systems are not allotted opportunities to deconstruct such complex issues simply because the systems are not culturally responsive in terms of treatment models. Mental health care professionals who have education and experience with understanding of such historical impacts of racism and microaggressions can offer such culturally relevant services that can help individuals and communities to deconstruct unhealthy coping mechanisms and begin healthier individuals and communities.

What the contractors reported and what is well known and established in the NS Department of Health and Wellness 2012 report, "Together We Can![5] is the lack of culturally responsive and timely care for members of the ANS community across the lifespan.

What the communities of Sunnyville, Linconville and Upper Big Tracadie echoed is the lack of community navigation into the conventional mental health and addictions programs, the lack of accessibility to treatment programs (transportation and time) and lack of mental health and addiction literacy in the community.

Member of these communities identified with getting support of addictions or mental health services only once someone was engaged in the criminal justice system. As is the case with many ANS communities, there remains a reluctance to reach out to police when issues of mental health and addictions intersect with intimate partner violence (IPV).

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[5] Mental-Health-and-Addictions-Strategy-Together-We-Can.pdf (novascotia.ca)

The legacy of police avoidance is rooted in systemic racism and colonialism faced by ANS communities. The thought of exposing, "family business" outside of the home among ANS communities remains a mutigenerational household "code", value or belief system. Such cultural codes have become an adapted practices within the ANS communities to resolve conflict. A practice that has worked to help mitigate harms to the family and/or community structure because police are historically viewed as a negative involvement and not a positive or helpers of peace. In fact, involving elders and other members of the local community such as clergy have become the common way of resolving conflict. This has become a historical practice due to the lack of trust and safety experienced between the police, criminal justice systems and Black communities; a problem that has been deeply rooted in racism and social inequalities.

Thus, issues of conflict and mental health, within ANS communities, often lack professional interventions that meet the needs of the people.

In fact, rural ANS communities, over the past 20 plus years, have been negatively impacted and community supports have deteriorated by the lure of urban areas due to the lack of employment and education opportunities. Such systems with ANS communities have further deteriorated and informal social supports systems that once served as a protective factor in small ANS communities across Nova Scotia have suffered greatly. Pastors now are rotational and have not been able to create meaningful cultural connections to the unique needs of the ANS community.

For the two AUBA churches in the community of Upper Big Tracadie and Lincolnville, Mr. Desmond's community, the clergy who pastors the local church were primarily African Immigrants, who's lived experience and community connections would not necessarily correlate with those of the local community. It is our understanding that Mrs. Shana Desmond had converted from the Baptist faith to the Jehovah Witness faith creating yet another gap in the informal social support network for the community or family to may have had access to from an ANS spiritual perspective.

History, Education, Employment and Mental Health from a Cultural Lens

The earliest written history of African descended people in Nova Scotia is dated in the early 1600s with the arrival of Mathieu Da Costa. Da Costa acted as an interpreter between the local Aboriginal community and the French colonizers. Given his role, one can only presume Da Costa had a pre-existing and trusted relationship with the Aboriginal community that enabled him to act as an interpreter. The early relationship formed between the Aboriginal and early Blacks (enslaved and free) speaks to ongoing struggles and collaboration today among the African Nova Scotian and Aboriginal communities. The relationship between these two historical, political communities is also extended into communities in which today several individuals identify as mixed race.

Parks Canada notes the arrival of Marie Marguerite: "{she} was captured in Africa and brought to Louisbourg at the age of 19 as a slave and she spent twenty years in the Loopinot household before being freed." Between, 1776-1815, Nova Scotia saw three waves of migration of Blacks: Loyalist migrants from the United States (1776-1782); the arrival of 500 Maroons from Jamaica (1796); and a migration from the United States following the War of 1812 (1813-1815).

In short, the African Nova Scotian (ANS) community has played an integral role in co-creating the fabric of Nova Scotian culture. It has only been in the past several years that the contributions of ANS have been formally acknowledged. However, the community continues to be disproportionately impacted by racism in the areas of education (BLAC Report, 1994, Lee Report, 2009, Beals, 2016) Justice (Marshall Inquiry, 1989, Williams, 2013, Don Clairmont et al., 2014) and Health (Together We Can, 2012).

In 2017, the African Nova Scotian Decade for Persons of African Descent Coalition submitted a report to United Nations stating that,

> African-Nova Scotians constitute a distinct and founding ("settled") people of Canada. Our significant presence and contributions pre-date the country of Canada by over 150 years; indeed, up until 1961 over half of all Black people in Canada were African-Nova Scotian.
>
> Our skills, experiences and contributions have shaped Canada; for example, the fact that we both endured and resisted decades of enslavement - with both free and enslaved Black people living together in Nova Scotia - shaped the building of Canada - and how Black people are viewed and treated… [the] African-Nova Scotian experience, wisdom, spirituality and resilience have been central to the campaign for equality in Canada - and is central to any hope of ever effecting equity for African-Canadians - and Canada.

It is important to note that Mr. Desmond's family of origin history is linked to the migration of Black loyalists who settled in many historical Black settlements throughout Nova Scotia. Such communities are known as Linconville, Sunnyville, Upper Big Tracadie, and so on. Despite the shrinkage and infringement on Black owned land and communities, many of these communities exist today.

Over 1000 Refugees from the War of 1812 settled in North Preston. Between 1796-1800, a large migration of the Jamaican Maroons settled in the communities of East Preston and North Preston. What is well known within the ANS community is that people from Black communities are historically marginalized in terms of employment opportunities and financial advancement. The hope of securing income was often linked to developing business opportunities through self-employment and skilled trades. Most often, such skills were passed down through generations of skilled workers and not necessarily formal education and training opportunities. Like the fate of many other ANS, they encountered systemic and interpersonal racism, which inhibited their capacity to achieve their goals.

Historian and theologian Dr. Peter Paris, writes of the following history:

> From the early days of Nova Scotia when slavery was accepted practice, the struggle for racial equality has gone on. It has been a grievously slow process in which whole generations have sometimes made no apparent progress.
>
> Indeed, when Blacks did attend school during the 1800s and much later, both the attitudes of teachers and the curriculum itself reinforced racial stereotypes which hindered the educational advance of Blacks for a long while…Racial discrimination manifested itself in many forms in everyday life. Blacks were not encouraged to become property owners or businesspeople. For various reasons and excuses, restaurants and

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public services were often refused to serve people of colour and for many years, jobs in local businesses and government positions were just not offered to Black People.

Like many communities in Nova Scotia the impacts of systemic racism are deeply rooted in the past and continue to manifest presently. For many ANS, the impacts and harms of systemic and interpersonal racism has been deeply felt. Access to culturally responsive services within systems such as education, healthcare and justice has had profound negative impacts on Blacks. Accessibility to such resources and services would have allotted Blacks to make healthy connections within such systems that often contribute one's trajectory in society. However, within the ANS community there is a feeling of mistrust among the systems that provide education, health services and protection. Although there has been some progress in terms of increased accessibility for ANS in some communities, mainly within HRM, access and trust among services continues to be a concern that requires ongoing consideration. Although there is limited written history of the ANS experience within such systems, the above noted disparities cross all government systems. For instance, The Black Learners Advisory Committee Report on Education, filed in 1995 with the Department of Education spoke to the disparities among ANS and addressed recommendations to address systematic inequalities for black learners.

Nova Scotia has a long legacy of systematic injustices when it comes to the Black community. This history is often captured inter-generationally through art and oral history. Community members such as Shauntay Grant, Amanda Carvery, Anne Johnson–McDonald et al, write books and produce plays speaking to the history and legacy of the Refugees, Maroons and Loyalists.

The legacy of racism lives on in ANS communities. For instance, North Preston continues to be the one of the oldest Black communities and is the largest intact Black community in Canada. The community continues to remain predominantly segregated. In fact, the May E. Cornish School in Lincolnville was the last segregated school to close in Canada and Nelson Whynder Elementary School, in North Preston, is the last segregated Black schools which remain operational in Canada today. The Nelson Whynder School has been maintained as part of the Halifax Regional Centre for Education mainly because of the level of racism and discriminatory treatment of Blacks in the Preston area and the desire of community members to keep their children within the community and away from experiencing further discrimination in White schools. It is also important to note that Segregated schools did not receive equitable funding as schools in white communities, which largely contributed to inequities among black communities. Despite the challenges of Black Communities in Nova Scotia, African Nova Scotians struggle to maintain a legacy of commitment to core values that focuses on faith, family and a sense of community.

Although Black communities strive to resist the stereotypical images and racist assumptions which impact on the psycho-social wellness of the entire community, there remains to be negative impacts of historical marginalization and disenfranchisement. Which include reasonable access to quality health care, education and employment, disadvantages that has spanned generationally for centuries.

Inquiries and task forces have been implemented to redress the impact of racism on the health/wellness, economic advancement, school achievement, and access to justice in the Black community. Each of these initiatives has made small inroads in their designated areas of interest. However, these initiatives have failed to accomplish an integrated, collaborative approach to generating meaningful and sustainable

change in the lives of members of the Black community who are most disenfranchised, stereotyped, and criminalized. Such is true especially for Black men.

The negative impacts of systemic racism continue to disproportionately impact Black communities in Nova Scotia. The impacts of the legacy of generational poverty in families and communities continue to date, given the continued high levels of unemployment in the Black community and the continued struggle of ANS youth to obtain adequate education and sustainable employment.

In short, the impacts of systemic racism are clearly noted in Nova Scotian history given there is limited written history or archives available to speak to the African Nova Scotian history in ANS communities. The lack of historical documentation speaks to the history of colonialism, systemic racism and the continued marginalization of African-Nova Scotian experiences inter-generationally.

The ANS communities across the province continue with resiliency and endeavor to maintain community and cultural practices that are influenced by the history of various migration experiences. The communities strive to maintain cultural values that support community respect for elders, protective communal parenting, a strong focus on educational attainment, and faith practices. However, it is important for the Court to be aware that ANS communities continue to be vulnerable and may not have access to the skills and resources to support and make significant impacts in addressing the health, contemporary cultural, economic and racial identity disparities.

The 'colour' line continues to manifest inter-generationally between the ANS and White communities, this is more predominately evident when it comes to rural Black communities. Thus, the impacts of interpersonal and systemic racism are multi-faceted.

For many Black Nova Scotians, there is a stigma associated with mental health issues. This is especially true for Black men. Many African Nova Scotian males avoid seeking treatment due to unfair treatment and being stereotyped or being label as "unstable" or "crazy." Such fears of mistreatment by the community and the health care system often viewed as a barrier for those in need of mental health services.

Mental health in the Black community is something that can easily be unchecked or left untreated. When it comes to mental health, people tend to suffer in silence, which often applies heavily to Black men. Years of racial oppression and the inability to react or speak on an emotional level left many Black men conditioned to suppress their emotions. You were born into a world where you were considered "less than" and reminded of it constantly. You are forced to form a tougher exterior and put mental and emotional well-being on the back burner just to survive – a mentality that has been passed down from generation to generation. Black boys and men are taught they must be strong and tough because the world in 10 times tougher. They grow up and are taught, there are people who don't like you because you of their skin color. It is tough to swallow, but they must come to terms with it quickly.[6]

[6] https://themight.com/2017/10/demo-taped-black-men-depression

Garfield Hylton reported, “For Black men we are taught to not deal with our feelings. Yeah, that’s true. I even told myself to “man up” last weekend, but then I wondered how many times had I flown off the handle when I kept it all bottled in rather than talking about it. If that’s the case, how many men turned their depression into anger, resulting in violence? How many lives could have been saved, caps and gowns been worn, or prison beds left unoccupied if brothers just had the chance to open up?”[7]

For many Black Nova Scotians, there is a stigma associated with mental health issues. This is especially true for Black men. Many African Nova Scotian males avoid treatment due to unfair treatment and being stereotyped or being label as “unstable” or “crazy.” Such fears of mistreatment by the community and the health care system often viewed as a barrier for those in need of mental health services.

Researchers (DeGruy, 2005, 2018, Carter et.al. 2013) and critical race literature, (Williams,2013, Aylward, 1999) speak to impacts of race and racism on the mental health, wellness and overall functional decline in the lives of people of African descent. Williams’s (2013) work is encouraging given she invites restorative practice as a meaningful early intervention and a tool for authentic rehabilitation and reintegration for offenders back into community. While Carter, DeGruy, and Poussaint (2000)**,** offer a critical clinical understanding of the impacts of culture, racism, and racial socialization on the lives of Black men and women post enslavement and the intergenerational impacts on a person mental health.

Dr. Kevin Washington, Ph.D. states:

> There is a history of being denigrated or dehumanized and not wanting to have one more thing be wrong; mental health doesn’t top the priority list and we don’t have the time to be sad or depressed because we have too many things we have to deal with right now.[8]

Early mental health interventions are proven most beneficial when administered during early diagnosis. Therapeutic counselling and skills training would be helpful in terms of emotions regulations and skills development. Despite the challenges Black men often experience, it is important to note that Mr. Desmond reached out for services, but such services did not appear to respond to his need. Such factors which could be considered relevant are noted above.

Additionally, the contactors (who facilitated the Mental Health 101 session throughout Nova Scotia in 2017-18) heard from participant and community leaders about the continued-out migration of Black youth from the community for work in larger centers and the ongoing impacts of systemic, Anti-Black racism as well as the educational gaps for Black learners in their communities all leading to community disruptions, substance use and mental health issues.

[7] https://abernathymagazine.com/depression-black-community/
[8] https://www.self.com/story/racism-mental-health-in-the-black-community

Several of the participants noted that for many of the young Black men in the communities going into the military:

> "Was a way out of poverty and gave them a skill, pension so they could come home with something. But they [military] are also coming back home damaged and we can't help them down here. We don't know how to help these boys when they come home all messed up. All we can do is love them and try to get them to get some kind of help. They come back different and we [community] see the drinking, yelling going on and we do nothing because we don't know what to do… my own brother killed himself down here. We don't even have someone we can as a family to talk to we all down here are suffering, and no one can help.
> The AUBA sent folks down here to help us out when Lionel killed his family. But that was only short term. Our community needs more help, and we are forgotten down here too".

Participants in the sessions across the province were unaware of the mobile crisis line operated by Nova Scotia. They also noted the lack of access to the service outside of the HRM stating, "it's not mobile down here for us." Many were aware of Kids Help Phone but did not know how to access the resources. They also acknowledged limited staffing at the local hospitals (Guysborough Memorial and St. Marth's) stating, "you're better off, if you can get a drive going to Sydney."

Challenges and Opportunities

When the contractors moved towards action planning, creating a list of resources and supports, community members reiterated of the gaps in service delivery to the local ANS community. The impacts of systemic Anti-Black racism in health care – recruitment, retention, and access to Black mental health support in the jurisdiction and the limited training, cultural competency and cultural humility by health care providers. One of the participants stated, "the doctors in the past got to know us down here and we got to know and trust them over time. Nowadays, you really don't get to know your doctor and they are in and out of here, they don't want to stay in small communities. The doctor back in the day was able to give you information you needed, and you would follow it."

A Way Forward

- Given the majority of mental health and addictions practitioners of ANS descent reside in HRM, it may be beneficial for NSH to partner with the Association of Black Social Workers and the Peoples' Counselling Clinic to provide virtual care to rural ANS communities. To do this effectively there must first be the prioritization of securing connectivity to internet service in rural Nova Scotia and resources to purchase devices to enable ANS in rural NS access to virtual care.
- The Canadian Armed Forces and Veteran's Affairs may also recruit Black and diverse mental health providers to provide culturally informed and responsive care with an emphasis on training in the areas of Psychosocial Services, Occupational Stress, General Mental Health and Addictions. Such care providers may also require unique culturally relevant supports, service and leadership that would help recruit and retain qualified health care professionals who provide culturally responsive services for active and retired military members.

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- To address IPV in the ANS community it may be helpful to include a cultural lens and the intersectionality of the Bystander Effect as a means to address and accessing resources and supports. The issues of racism and stigma in the ANS must also be understood as integral to the approach.
- NSH should recruit and provide educational scholarships for Black registered nurses and nurse practitioners. The nurses should be team members in local health clinics and in integrated, mobile, health centres. The Module framework was instrumental in the St. F.X. Coady institute and education department connecting the Black communities in Guysborough County with resources and in-time culturally and community relevant support around education attainment.
- The Network of Black mental health provider built from the work of the NS Mental Health and Addiction Strategy should be supported and adequetely resourced. The support of these individuals and the expansion of the Network is key to the expansion of culturally competent mental health and domestic violence services. The potential is to improve mental health outcomes for People of African Ancestry living throughout the province but specifically targeting under-served and inequitably served, ANS communities in rural Nova Scotia.

PETER JAFFE REVIEW PREPARED FOR DESMOND FATALITY INQUIRY

Report Prepared for The Honourable Warren K. Zimmer,
Judge of the Provincial Court of Nova Scotia

Report Prepared by Dr. Peter Jaffe,
Director Emeritus, London Family Court Clinic,
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Report Date: October 22, 2021

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The Honourable Warren K. Zimmer,
Judge of the Provincial Court of Nova Scotia
Desmond Fatality Inquiry
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Canada

Re: Desmond Fatality Inquiry

Your Honour

I was retained as an expert in domestic violence and domestic homicide to provide a report and testimony for The Desmond Fatality Inquiry. I have reviewed the evidence heard to date and all the documents produced for the Inquiry. I am a licenced clinical and forensic psychologist in Ontario. I leave the analysis of the mental health issues to your psychiatric expert, Dr. Theriault, and limit my report to domestic violence, domestic homicide and the overlap of domestic violence and mental health issues that dominate this matter.

The Inquiry is focused on the events of January 3, 2017, when the bodies of Corporal Lionel Desmond, a veteran of the war in Afghanistan, his wife Shanna, their 10-year-old daughter Aaliyah, and Cpl. Desmond's mother Brenda, were found in a home in Upper Big Tracadie, Guysborough County. It is believed that Cpl. Desmond took the lives of his family members before he took his own life. This report is written with that assumption.

I understand that The Inquiry's mandate is to determine the circumstances under which these deaths occurred, as well as some specific issues that include whether Cpl. Desmond and his family had access to the appropriate mental health and domestic violence intervention services leading up to their deaths. I understand that the Inquiry will conclude with a written report filed with the Provincial Court with Your Honour's findings and recommendations.

This report is based on information gathered by the Inquiry including the records of professionals who were involved with the deceased as well as transcripts from the extensive proceedings to date. Appendix A provides a list of the materials I was provided. My opinion is based on my file review, the literature in this field and my expertise as a mental health professional who has specialized in the area of domestic violence and domestic homicide for the past 45 years.

My report is divided into the following sections: qualifications of the author, an overview of current knowledge about domestic violence and homicide, an overview of Cpl. Desmond and his wife Shanna's history and their interactions with multiple service providers across different jurisdictions and ministries, known risk factors for domestic homicide in the Desmond case, timelines for these risk factors, and recommendations for the Inquiry's consideration.

QUALIFICATIONS OF AUTHOR

I am a registered psychologist in Ontario, Professor Emeritus in the Faculty of Education and the former Academic Director (2005-21) of the Centre for Research and Education on Violence against Women & Children at Western University in London, Ontario. I am the Director Emeritus for the London Family Court Clinic. For over 45 years, most of my research and clinical work involves adults and children who have been victims of abuse and involved with the criminal, family, and civil court systems. I have co-authored eleven books, 40 chapters and over 90 articles related to children, families and the justice system including Children of Battered Women, Working Together to End Domestic Violence and Preventing Domestic Homicide: Lessons Learned from Tragedies.

I have presented workshops across the United States and Canada, as well as Australia, New Zealand, Costa Rica and Europe to various groups including judges, lawyers, mental health professionals and educators. Since 1997, I have been a faculty member for the US National Council of Juvenile and Family Court Judges' program on "enhancing judicial skills in domestic violence cases". I have been an expert witness in three Ontario inquests into domestic homicides as well as one in PEI and one in Alberta. I am a founding member of Canada's first Domestic Violence Death Review Committee through the Office of Ontario's Chief Coroner. I am currently working on national study, funded by the Social Science & Humanities Research Council, on domestic homicide in vulnerable populations together with over 50 academic and community partners across Canada. The study involves an examination of risk assessment, safety planning and risk management strategies in domestic violence cases. A Curriculum Vitae is attached (Attachment A).

STRUCTURE OF REPORT

This report is organized into two sections – the first section provides a background on current knowledge about domestic violence and the common dynamics between victims and perpetrators. This section is based on my experience in the field working with the police and court system as well as research in the field. The second section provides a synopsis of the Cpl. Desmond's family and mental health history as well as his relationship with his wife leading up to their deaths. I end with my major clinical findings and recommendation for the Inquiry's considerations.

SECTION ONE: LITERATURE REVIEW

This section provides an overview of the current literature on domestic violence[1] and domestic

[1] The term domestic violence is used in this report – it is intended to be interchangeable with Intimate Partner Violence – because an estimated 80% of the victims are women, it is also considered under the broader definition of gender-based violence -see https://women-gender-equality.canada.ca/en/gender-based-violence-knowledge-centre/about-gender-based-violence.html

homicide[2] that includes common dynamics between victims and perpetrators. Understanding the nature of domestic violence and the dynamics between victims and abusers is necessary to properly address the questions raised during the Inquiry, including the effects of domestic violence on victims, on children, their psychological and physical reactions, victims' remaining in the control of their abuser, victims' minimizing the abuse and/or reluctance to report abuse, and the risk factors associated with escalating dangers and potential domestic homicides. The research in the field is summarized below and is based on national surveys on domestic violence, reports to police as well as other agencies, detailed interviews with victims and reports from domestic violence death review committees. The section highlights the existing work in the field with references provided in Appendix C to the original works being cited and quoted.

Domestic Violence - refers to violence and abuse that occurs in the context of an intimate relationship. This relationship can refer to a dating relationship, co-habitation or marriage and includes same sex relationships. Although domestic violence may be an isolated incident, the research in this field concerns itself with repeated abuse and patterns of abuse that may endanger victims and create the most significant physical and psychological consequences. Abuse is comprised of more than individual acts and often refers to one person's attempt to control and dominate their partner through a variety of means in the relationship. Although men and women may be perpetrators of violence, the research would suggest that male violence against women is more severe in terms of fear, hospitalization for injuries, absenteeism from work and homicide. Domestic violence can be considered to take four major and distinctive forms, although these are very rarely discrete:

Physical Violence - may include a range of behaviours from pushing and shoving, to kicking, punching, strangling, and the use of weapons. Most women report that violent incidents progress in terms of severity over time, coupled with a reduction in the interval of violence-free time between assaults. Injuries that are sustained because of such assaults range from minor scratches and bruises, to lost teeth, lacerations which require stitches, and broken bones. Homicides represent the extreme end of the range of physical assaults.

Sexual Abuse – relates to any unwanted, nonconsensual activity that can range from touching to forced vaginal or anal penetration.

Psychological and Emotional Abuse – refers to any gestures, words or activities that serve to threaten, intimidate, undermine, humiliate, and isolate the victim. These behaviours can range from verbal put-downs to death threats, which may be directed toward the victim and/or the victim's loved ones, such as her children and parents. The abuse may also involve stalking and harassing behavior and threats to commit suicide if the victim leaves the relationship.

Psychological and Emotional Abuse may include Technological Abuse which relates to behaviours

[2] Since most domestic homicides involve the killing of women, the term femicide is often used in these cases as part of a broader definition of the killing of women and girls based on their gender as the extreme end of violence and discrimination against women and girls (http://femicideincanada.ca/).

where a partner misuses technology to harass, stalk, threaten, and harm the victim. These acts can range from making threats via cell phone, text messages, and email, blocking caller ID so the victim is unaware that the perpetrator is calling, sending, and/or posting pictures or videos of the victim for the purpose of distressing or harming the victim, and accessing victim's accounts (email, phone, social media, etc.) without the victim's consent. The use of technology to monitor and control victims can be invasive and traumatizing.

Economic Abuse – encompasses any activity that deprives a woman of the ability to provide for her basic needs and/or those of her children.

Domestic homicide – The killing of a current or former intimate partner, their child(ren), and/or other third parties. An intimate partner can include people who are in a current or former married, common-law, or dating relationship. Other third parties can include new partners, other family members, neighbours, friends, co-workers, helping professionals, bystanders, and others killed in the context of the incident.

Coercive control – describes a pattern of behaviours to assert control over a person by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive control is now being recognized in law such as the amendments made to the Divorce Act that include various forms of family violence such as a pattern of coercive and controlling behaviour, **or** behaviour that causes a family member to fear for their safety or the safety of another person (see https://www.justice.gc.ca/eng/fl-df/fsdfv-fidvf.html#s1). Examples of this conduct are summarized in the chart below which provides a framework for the overall patterns of behaviours (Power & Control Wheel – see https://www.theduluthmodel.org/wheels/understanding-power-control-wheel/)

Children Exposed to Domestic Violence **–** refers to a child seeing, hearing, being told about, or seeing the aftermath of abuse and coercive control against an intimate partner who is their parent. Children who are exposed to domestic violence are at risk for both short and long-term harm, including emotional, behavioural, and developmental problems. (Jaffe, Wolfe & Campbell, 2011). Exposure to domestic violence has been recognized as a form of child emotional abuse.

Overall typology of domestic violence

Domestic violence is not a unitary phenomenon, and it can vary in severity and frequency. Leading scholars in the field have proposed different typologies to explain the diverse patterns of violence that can exist in intimate relationships. The three main types of domestic violence are: 1) Situational couple violence, which is the most common form of domestic violence, does not exist within a context of an attempt to control all aspects of a partner's life, but is enacted as a means of controlling a specific situation. It is often a disagreement that may escalate into violence, and it may be an isolated incident or a recurring pattern in a relationship. Women and men may be part of such violence although men inflict more serious injuries and engender more fear. 2) Intimate terrorism is a type of domestic violence that occurs within the context of

coercive control and is predominantly perpetrated by men in heterosexual relationships. The perpetrator entraps the victim in a relationship by using multiple forms of abuse such as threats, economic control, isolation, and male privilege as means to establish power within the relationship. This effectively diminishes victims' personal resources (e.g., confidence, self-esteem), financial resources (e.g., money to escape, stable employment), and contact with support networks (e.g., family, friends, shelters). Intimate terrorism happens less frequently than situational couple violence but is most destructive in terms of physical and psychological consequences for victims. 3) Violent resistance is the type of domestic violence that occurs when a victim of intimate terrorism fights back. It usually refers to a woman coping with her repeated victimization by fighting back against a dominating, abusive man.

Why Victims Stay or Return to an Abusive Relationship

Leaving an abusive relationship is a difficult process which is often underestimated by victims and those who attempt to support them, as it typically involves numerous stressors including relocation, economic instability, fear, legal actions, child custody issues, disrupted social networks, and termination of emotional attachment with the perpetrator. Victims may feel responsible for the abuser and feel guilty in leaving the relationship. Victims typically undergo several shifts in their thinking about the abuse before leaving permanently, and victims recently out of an abusive relationship may have greater psychological difficulties than those who are still in it. They may experience ongoing harassment and threats after separation.

Research examined the various aspects of victims' help seeking through the narratives of women in a domestic violence shelter. Many victims seemed to be cumulatively affected by their partners' abuse and control tactics combined with the failed or inadequate responses by social (e.g., family) and institutional outlets (e.g., social services), and ultimately returned to their partners. For all these reasons, victims experience extreme difficulties to end abusive relationships, live productive lives, and avoid re-assault. Victims may decide to remain in a relationship out of their love for the abuser, hope that he will change, for the sake of the child(ren) having a father, fear, isolation and religious or cultural beliefs. Victims may leave many times before they make a final break. Separation tends to be more a process than an event.

Isolation is often a critical part of an abuser's attempt to control their partner and trap them in the relationship. During an abusive relationship, abusers may try to cut off the victim from family and friends. They may resist the victim working outside the home. The more isolated a victim becomes, the less likely a third party will be witness to the abuse as well as the aftermath of the abuse in terms of physical injuries or psychological problems. Isolation prevents a victim from being exposed to perspectives other than the abuser's, which serves to reinforce a victim's reliance on the abuser's way of thinking, including their rationale for the abuse.

Patterns of Disclosure

Disclosing abuse is a significant step for a victim and delaying disclosure is common. There are many factors that relate to when and whether abuse is disclosed.

There are many misconceptions in the mind of the public about victims' help-seeking behaviours. Most people would think that victims of criminal behaviour would readily seek the assistance of police; however, it is the exception rather than the rule that victims of abuse by their partner report their victimization to the authorities. Only one in five victims call the police according to the most recent Statistics Canada report[3]. Close to one quarter of victims never tell anyone of their experiences. When abuse is finally reported, it tends to be at a point of desperation when the violence has escalated, and children may be seen to be in danger as well. Often third parties such as neighbours, family members or co-workers may call police out of their concern.

Research in this area also suggests a link between coping style and disclosure pattern such that victims who tend to use avoidance as a coping strategy tend to take longer to disclose their abusive experiences. Individuals who cope with their abusive experiences through avoidance also tend to minimize the seriousness of their abusive experiences, both at the time of their occurrence as well as in the years that follow. To contemplate disclosing abuse to authorities is that much more formidable given the fear of not being believed, potentially being re-victimized, and a belief that the possible consequences for the abuser will not justify the risks associated with disclosing.

Victims are reluctant to contact police due to a variety of factors. Some of these factors may include privacy concerns, fear of reprisal, and their desire to protect offenders. Overall, victims are more likely to call for self-protection and because they perceive the assaults to be more serious. Research has shown that perpetrators may threaten further harm if the victim engages with the police; women have reported further assaults even after arrests and incarceration. Racialized women and Indigenous women may be more hesitant to call the police because they are worried about racism and that the response may make the situation worse and that the only remedy may be incarceration rather than assistance.

Dynamics of Abusive Relationships

Often, the first incident of violence does not occur until after the woman has made an emotional commitment to her partner. The foundation of trust, dedication, emotional vulnerability, and intimacy has commonly been built prior to the infliction of any violence. Out of this sense of trust and affection, empathy for her partner is born. Most women report being completely shocked by the first assault and want to believe the perpetrator's professions of remorse and promises that it will never happen again. For a period, the abuser reverts to the loving, attentive partner he resembled in the beginning. The abused woman typically believes that the 'real" man is the one who is kind, supportive and nurturing; the one that emerges after an explosion. In contrast, she tends to believe that the violent man is an aberration of her loved one, which is reinforced by the perpetrator's pleas and rationalizations of his violent behaviour. Her compassion for her partner plays a significant role in her acceptance at some level that her partner was violent because of work stress, financial pressures, the over consumption of alcohol, health problems,

[3] Conroy, S. (2021). Family violence in Canada: A statistical profile, 2019. Juristat. Statistics Canada Catalogue, (85-002).

mental health difficulties, co-worker conflicts, a profound sense of aloneness or an unresolved issue from childhood. Instead of feeling outraged or appalled by the assault, as one may expect, numerous abused women end up feeling sorry for their abuser.

Subsequent assaults, whether physical or sexual, occur within a broader and ongoing context of psychological abuse, accompanied by promises of change. Women commonly report that by this stage of the relationship they have become immobilized by fear, experience an eroded self-esteem, and believe in the abuser's absolute control over their lives. Many women describe these relationships as feeling like they are "walking on eggshells." Some abused women unconsciously study their partner, attempting to learn the subtle signs of an impending assault. From the perspective of the victim, the violence is random and arbitrary. Victims describe feeling like hostages within their own lives, where their behaviour is directed almost exclusively at trying to accommodate the demands of the perpetrator to avert another assault. Confronted with the reality of such a bleak existence, many question why the victim simply did not leave her abusive partner.

Research in this area also clearly suggests that for every individual domestic assault that comes to the attention of the police, many times that number occur without police involvement. One research study involving batterers themselves found that for every assault which comes to the attention of the authorities, abusers commit approximately thirty assaults. Survey data of victims suggest that most abuse survivors do not contact the police. There are economic differences, with abuse survivors more likely to contact the police or go to a shelter if they have less economic resources. Women representing a higher socio-economic status tend to cover up the abuse to protect the abuser unless the abuse is severe. They may use more informal support such as friends and family.

Domestic Homicides

Domestic homicides refer to homicides that happen in the context of an intimate relationship and are perpetrated by a current or former intimate partner. These deaths can include the couple themselves or third parties such as children, new partners, other family members, or professionals such as police who intervened. Domestic homicides account for about 1 in 8 homicides around the world.

Women and girls bear by far the greatest burden of domestic homicide. Across 66 countries, the proportion of intimate homicides committed by intimate partners is six times higher for female homicide than male homicide (39% vs 6%). In 2017 approximately 30,000 women were killed by an intimate partner across the globe, which represents 82 women killed per day.

In Canada, between the years 2010 and 2019, there were 815 domestic homicides with women representing 79% of all victims. Over half of these homicides involved vulnerable populations including Indigenous women, women living in rural and remote part of the county, immigrants and refugees and children living with domestic violence (see www.cdhpi.ca). One in eleven victims of domestic homicide were children. The populations that are vulnerable share several

critical factors – a sense of isolation, more limited access to service, economic challenges and social norms that may condone or minimize domestic violence. Nova Scotia had 25 victims which represents 3% of the total which is consistent with 3% of the Canadian population it represents. According to the Nova Scotia Advisory Council on the Status of Women, 37 women were murdered by their intimate partner in NS between 1999 and 2018. As with the Desmond case and the mass shootings in April 2020 that is the subject of a Mass Casualty Commission, children, friends, neighbours, professionals, and other 3rd parties represent significant numbers of other domestic homicide victims.

Domestic homicides appear to be most predictable and preventable of all homicides. Friends, family, coworkers, and professionals who had contact with the victim and/or perpetrator often report warning signs that had concerned them. Often friends and family did not know what to do or say. They may have been hesitant to share their observations and worries. Frontline professionals may have lacked awareness or training about domestic violence warning signs. Many people wish they had taken action such as speaking to the victim or the perpetrator and encouraging them to get help. Some wished they had called the police or engaged the justice system much earlier for protection.

Homicide-Suicide & Familicide

Internationally, between 25 and 30% of domestic homicides are homicides-suicides. In Ontario over the period of 2002-2018, there were 420 domestic homicide cases – of those 29% or 120 where homicide-suicides. In these cases, the perpetrator – kills himself after the homicide – women and children are 90% of the victims on domestic homicide-suicides.

Familicide refers to perpetrators who kill multiple family members – 95% of the cases involve men who kill their partner and other family members. These incidents are usually preceded by a history of domestic violence, intimidation, threatening acts, and a history mental health problems. Common motivation for men committing familicide involved losing control over their family through separation and/or financial difficulties. These individuals are often motivated by anger, jealousy, and revenge. In some cases, familicide was the man's final attempt to regain control to which he felt entitled but was losing.

According to a Canadian study of familicide over a decade (2010-2019), there were 25 such homicides with 69 victims. Men were the perpetrators in all but one case. These men were most often in the 25 to 34 years of age range, with a history of domestic violence and an actual or pending separation. These Canadian familicides were more likely to include a perpetrator suicide in homes in rural communities.

Child Homicides Associated with Domestic Violence

Children are impacted by their exposure to domestic violence. Exposure refers to a child seeing, hearing, being told about, or experiencing the aftermath of abuse and coercive control against an intimate partner who is their parent. Children who are exposed to domestic violence are at

risk for both short and long-term harm, including emotional, behavioural, and developmental problems. (Jaffe, Wolfe & Campbell, 2011). Exposure to domestic violence has been recognized as a form of child emotional abuse. At the extreme, children who are exposed to domestic homicide or can become homicide victim themselves.

Children in families where there is a domestic homicide always pay a heavy price. Children lose parents and are vulnerable to a cascade of impacts and adversities associated with that loss. They are directly and indirectly traumatized by the murder itself, sometimes being direct witnesses or being the first ones on the scene and other times experiencing trauma associated with indirect knowledge of events. Too often, children carry crushing guilt associated with a misperception that, if they had only behaved differently, reached out sooner or been "better" in some way, then they could have prevented the homicide from occurring. Children also sometimes pay the ultimate price as victims of homicide, killed as an act of domestic violence-related revenge against their mother.

Most child homicides in Canada are perpetrated by parents. Fathers are responsible for the homicide in approximately 60% of the cases. Living with domestic violence is a significant risk factor for child lethality. The Ontario Domestic Violence Death Review Committee (DVDRC) reported 471 homicide or homicide-suicide victims with domestic violence involvement between 2002 and 2018. Of the homicide victims, 9% were children killed in the context of domestic violence - 8 out of 10 of these child domestic homicides were perpetrated by fathers.

Research in this area suggests that there are three principal situations where children are killed in the context of domestic violence: (1) during an attempt to protect their parent from violence; (2) as an act of revenge against one's partner (e.g., partner ended relationship); and (3) in a murder-suicide by a parent who decides to kill the whole family. In these cases, it would appear that the perpetrator intended to harm his (ex)partner as a way to punish or exert final control over the family.

There are several common risk factors that increase the likelihood of a domestic homicide. Some research has suggested the following risk factors that may be associated with the risk of child domestic homicide: history of child abuse, prior involvement with agencies, history of domestic violence within the home, perpetrator unemployment, actual or threatened parental separation, perpetrator psychological instability, perpetrator substance abuse.

One Ontario study examined the differences in risk factors between child domestic homicides, adult domestic homicides where children were present but not killed, and adult domestic homicides where there were no children in the family. Results indicated no unique risk factors that distinguished adult from child domestic homicides. Most cases had seven or more common risk factors present indicating a high-risk situation. Of concern, only one case had any record of a risk assessment that included the risk for the child which confirms to the extent to which children are overlooked in these cases.

Risk Factors Associated with Domestic Homicides

There has been a fair amount of research that has looked at risk factors associated with domestic homicide. The most common risk factors identified are a history of domestic violence and a separation. The Domestic Violence Death Review Committee of Ontario has identified 41 risk factors associated with domestic homicide, with the most prevalent being a history of domestic violence, followed by an actual or pending separation, obsessive behaviour displayed by the perpetrator, and the perpetrator being depressed. Over 70% of the cases reviewed in Ontario had seven or more known risk factors (see Appendix A and Table A on pages 22 and 23 for a review of all the factors which were present in the Desmond case).

From 2003-2019, the Ontario DVDRC has reviewed 351 cases, involving 496 deaths. Of the cases reviewed, 67% were homicides and 33% were homicide-suicides. Approximately 70% of all cases reviewed from 2003-2019 involved a couple where there was a history of domestic violence and 66% of the cases involved a couple with an actual or pending separation. The other top risk factors were:

- a perpetrator who was depressed (48%)
- obsessive behaviour by the perpetrator (45%)
- prior threats or attempts to commit suicide (42%)
- a victim who had an intuitive sense of fear towards the perpetrator (42%)
- victim vulnerability (44%)
- perpetrator displayed sexual jealousy (39%)
- prior threats to kill the victim (35%)
- excessive alcohol and/or drug use (40%)
- a perpetrator who was unemployed (40%)
- history of violence outside the family (34%)

Some of the original research on identifying risk factors originated over 3 decades ago from the work of Dr. Jacquelyn Campbell and her colleagues from Johns Hopkins University in Baltimore Maryland. They compared aproximately 1,000 cases of domestic homicide to 1,000 cases of domestic violence and found certain factors were significantly associated with the homicides. These factors include prior domestic violence, separation, controlling behaviour, strangulation, stalking, access to guns and perpetrator unemployment amongst many others. Her research led to one of the first risk assessment tools, commonly used by advocates for abuse victims called the Danger Assessment Scale (DA). The DA identifies the risk for lethality for victims of domestic violence by assessing the severity and frequency of the past or current abuse and the number of risk factors present that are directly associated with the risk of domestic homicide.

Risk Assessment Tools

The primary purpose of conducting domestic violence risk assessment is to prevent violence.Risk assessment helps to prioritize cases for intervention and identify monitoring and supervision strategies, safety plans for victims, and management and rehabilitative options for offenders. A

secondary purpose of domestic violence risk assessment is to improve the accountability, transparency, and consistency of decision-making.

Professionals in the domestic violence field have been conducting risk assessments for decades often basing their assessments on experience and intuition. This informal approach, referred to as unstructured clinical decision making has been criticized as being highly subjective and lacking reliability, validity, and accountability. Unstructured clinical decision making may also miss important factors found in research that inform appropriate and effective interventions. This approach allows for personal preferences, biases, and specific specialized trainings of the professional to influence intervention and prevention strategies rather than relying on empirically studied risk factors and strategies widely accepted and used in the field.

There are two structured approaches to risk assessment utilized in the domestic violence field: 1) actuarial assessment and 2) structured professional judgment approach. The actuarial approach to risk assessment involves using a tool that contains risk factors selected through empirical research to obtain a score that indicates a perpetrator's risk of reoffending. An actuarial tool is distinguished from other assessment methods by how the items are selected, combined, and interpreted, rather than which items are used or whether they are measured at one point (i.e., static) or used to measure change (i.e., dynamic). It allows an assessor to see how an individual perpetrator's risk compares with that of other known perpetrators. It also provides an estimate of the probability of reoffending (according to a specified outcome and time frame) based on follow-up research with many individuals.

The structured professional judgment approach to risk assessment involves assessing risk according to guidelines that reflect theoretical, professional, and evidence-based knowledge about domestic violence. The guidelines include the minimum number of risk factors that must be considered for each case; recommendations for gathering information that will be needed for the assessment (e.g., using multiple sources and methods); proposed strategies for communicating opinions about risk; and suggestions for implementing risk management plans. The structured professional judgment approach to risk assessment differs from the actuarial approach by allowing some professional discretion in the determination of risk.

Any risk assessment needs to be considered through the lens of the unique vulnerabilities of each victim. This can only be determined by having the victim, or a victim's advocate inform the process. Subsequently, she needs to be advised of relevant information from risk management plans. Common tools used in Canada by the police and domestic violence services include the Ontario Domestic Assault Risk Assessment Guide (ODARA), Spousal Assault Risk Assessment Guide (SARA) and the Danger Assessment (DA)[4]. Practices vary widely across Canada.

[4] The ODARA was designed to predict the likelihood of re-assault rather than homicide and is most often used by police. The DA was designed to predict lethal violence and is most frequently used by shelters for abuse victims.

Domestic Violence Death Review Committees

A major development in the domestic homicide field has been the development of multidisciplinary review teams that examine these homicides in detail after the court process has been completed. These death review committees are now found in seven Canadian provinces (ON, NB, MB, BC, QC, SK, BC) with Ontario's have the longest serving since 2003 through the Office of the Chief Coroner. All annual reports are found on-line and provide a summary of cases reviewed in that year as well as accumulative statistics of background of the victims and perpetrators, risk factors present prior to the homicide and community agencies involved. Most US states have similar death review committees. There are eight jurisdictional review committees in Australia. The United Kingdom and New Zealand operate death reviews at a national level. Although each jurisdiction varies in legislation, funding, and process model for their reviews, the goals are mostly common ones. The central goal from the reviews is to identify how to prevent a homicide in similar circumstances in the future. The reviews most often make recommendations for improved training, resources, and collaboration across service sectors and education of those closest to victims and perpetrators – neighbours, friends, family members and co-workers.

Standardized death reviews allow for a deeper exploration of family histories and missed opportunities for intervention. The evolving research and publication of death review reports highlight the fact that domestic homicides do not happen out of the blue. Most often there is a trail of missed opportunities for interventions to find safety for victims and risk management for perpetrators. At the same time, it is obvious that domestic homicides are a heterogeneous problem to understand. Although there may be overlapping warning signs, each domestic homicide may have unique characteristics. Unique characteristics arise from the social circumstances and life context for the victim and perpetrator. Whether it is a teen dating relationship, or an aging couple married for over 50 years, urban or rural family, Indigenous or non-Indigenous victim, immigrant or refugee perpetrator, each circumstance poses a need for a different lens to understand the risks and the context for the homicide.

Domestic Violence and Homicide & Depression and Suicide Risk Factors

Most people suffering from a mental disorder are not violent and much public education has been directed towards changing that perception and any stigma associated with these difficulties. However, some mental disorders may be associated with a higher likelihood of violence than the general population. Psychiatric disorders, particularly schizophrenia, personality disorders, and substance use disorders are clearly associated with increased relative risks of violence. Rates of violence perpetration of 6–10% in personality disorders and schizophrenia spectrum disorders, and over 10% in substance misuse suggest some diagnoses require more thoughtful consideration of risk of violence above the general population base rate. A diagnosis of PTSD may mean 2 times the likelihood of violence but may depend on other risk factors as well such as exposure to violence in childhood. The research on the risks from PTSD often comes from military samples and is described in more detail in a specific section below. In terms of general incidence of violence (not family violence per se), it is higher in returning veterans who served in combat and were exposed to multiple traumatic events as well as having

greater hyperarousal symptoms – i.e., an abnormally heightened state of anxiety that occurs whenever you think about a traumatic event.

Amongst the most consistent and least recognized risk factors in domestic homicide cases are the perpetrator's depression and prior threats to kill themselves. This factor is present in approximately half of the domestic homicides reviewed in Ontario. This factor is significantly higher for homicide-suicide cases. Depression and suicide threats are recognized as threats to the individual but most often overlooked as red flags to harm others. That is, mental health professionals are alert to threats of self-harm or suicide but rarely make the links to potential homicides. Often professionals do not ask a client who is depressed or threatening self-harm or suicide detailed questions about the perpetrator's ideas on how to manage their sense of losing their partner.

It is common from death review committees to find perpetrators had contact with medical and mental health providers or programs in their communities who did not recognize domestic violence-related risks. General and specialized mental health professionals should be able to recognize and address risks associated with domestic violence and mental health and/or relationship concerns. Recommendations from death review committees have pointed out that professional training on this topic is needed for practicing service providers, and education curricula for new professionals needs to be updated to include provisions for assessment and management of risk for domestic homicide. Women who present with a history of domestic violence and concern about the mental health of their partners/ex-partners need to be taken seriously. Men who present with relationship concerns, obsessive thoughts, depression, and suicidality need to be properly assessed for domestic violence risks. General mental health service providers need to make their services more accessible and responsive to those who have been victims and perpetrators of domestic violence. There is often a lack of collaboration across mental health, justice, and domestic violence specialist services. That collaboration is needed so that those cases presenting as highly concerning can be better managed.

Domestic Violence and Homicide & the Military

There have been several government reports which suggest a higher rate of violence against women within all male-dominated institutions, including the military. A recent external review of violence against women in the military by retired Supreme Court Justice Deschamps indicated that there is an underlying culture in the CAF [Canadian Armed Forces] that is hostile to women and conducive to more serious incidents of sexual harassment and assault. There have been ongoing attempts of late to acknowledge these problems and to promote a significant cultural change (Deschamps, 2015).

The inherent risks for violence against women who are members of the military extend to military partners and spouses as well. Although it is challenging to research domestic violence in the military, because of the implications of reporting this behavior, some estimates of prevalence put rates as high as threefold more common among active soldiers and veterans than the general population. US studies demonstrate that reported rates of sexual assault in the military are higher than those

reported in the general population.

There are several risk factors for domestic violence associated with the military. For example, the military includes many young individuals, the highest risk age group for experiencing domestic violence. Mental health disorders from combat exposure have been linked to domestic violence with PTSD receiving the most attention. Some studies have found that hyperarousal symptoms are heightened in combat veterans. That increases their appraisal of threat, which could be associated with domestic violence. Desensitization to violence is another risk factor. Desensitization may lead to increased interpersonal violence in general, and violence toward women specifically. The military environment also promotes hypermasculinity, an extreme form of masculinity based on beliefs that endorse polarized, and stereotypical gender roles. This environment emphasizes control, power, competition, and tolerating pain, rather than disclosure of assaults.

In later years, family stresses like adjustments to nonmilitary life, ongoing financial dependency, and ongoing mental health problems may compound the risk for domestic violence. Adding to the complexity of these problems is the stigma related to experiencing mental health concerns and military veterans' reluctance to self-identify and seek assistance. Both active-duty service members and veterans have difficulty seeking mental health care. Although this stigma is beginning to ease, those who wish to get help continue to fear not being taken seriously, job loss, or being looked down upon by their leaders and fellow service members Although soldiers frequently report alcohol concerns, very few are referred for treatment[5].

At the same time, military spouses and partners are reluctant to disclose the violence. They fear job loss when they are dependent on their spouse for housing and economic security. Partners and spouses also often experience isolation resulting from frequent moves and are unable to learn about and establish trusting relationships with potential sources of support. These issues are further complicated by a lack of trust in how complaints are dealt with by supervisors.

Several risk factors have been identified by domestic violence death review committees that are particularly relevant to the military. First and foremost, military personnel have ready access to firearms as well as the training and skills to utilize them. A career in the military involves high levels of stress and ongoing exposure to violence at work which are breeding grounds for the development of PTSD and related mental health concerns, including depression and substance use, both of which are well-established risk factors for domestic homicide. Domestic violence and domestic homicide are also associated with misogynistic attitudes, which are more likely to be found within patriarchal workplaces. There is considerable evidence about how military institutions support these cultural norms. The routine use of power and control to gain compliance is another risk factor.

Among members of the military, combat exposure correlates with intimate partner violence

[5] As a note to the reader, this section reviews the field in general but not all the points relate to Cpl. Desmond. This point is less relevant because Cpl. Desmond was actively seeking help until the end and had repeatedly sought help in the past for his mental health problems.

perpetration. Trauma exposure and subsequent PTSD symptom severity may be important links to the perpetration of intimate partner violence together with other risk factors such as childhood abuse. However, combat exposure and partner aggression are not associated when controlling for PTSD symptoms. However, perceived threat was positively related to reports of violence. This finding is consistent with male perpetrators of intimate partner violence who perceive more malevolent intent (e.g., she was trying to pick a fight) on the part of their partners than men who are not perpetrating intimate partner violence (regardless of marital conflict per se). It may be that perceiving higher levels of threat during deployment, may increase risk for PTSD symptoms and independently contribute to likelihood of male veterans perpetrating intimate partner violence via a tendency to attribute malevolent intent to their partners (i.e., they may feel more threatened by their partner's actions).[6]

In addition to these career-related risk factors are several other more general risk factors that may play a significant role within military populations. Some research suggests that individuals who join the military are more likely to come from troubled families with a history of abuse. Military personnel and families tend to be younger than other career-oriented workplaces, triggering domestic violence risks associated with younger age groups. While these risk factors are not specific to the military, they are part of the fabric of the profession, leading to workplace cultures that may inadvertently support domestic violence. There are also several victim vulnerabilities that impede help seeking in victims of domestic violence. There may be a heightened concern that reporting will result in criminal proceedings, employment loss, and incarceration.

SECTION TWO: BACKGROUND HISTORY OF CPL. LIONEL DESMOND

I am in no position to assess Lionel Desmond and Shanna Desmond's motives for their actions and the decisions that they made. I never had the opportunity to meet them or provide a clinical assessment before their deaths. I am left to speculate after the fact based on the comprehensive work of the Inquiry and detailed records. However, their actions do follow similar patterns of many perpetrators, victims, and survivors in these circumstances. There has been extensive information through the documents and testimony from family members at the Inquiry that provides context for Lionel Desmond's relationship with his wife Shanna and what happened when he returned home from Afghanistan until the tragedy that is the focus of this Inquiry.

The couple began dating when he was 18 and she was 16 years of age. They were married after Shanna graduated from high school. According to Shanna's mother, the couple got married before he was in the army and their daughter, Aaliyah, was born weeks before he was deployed overseas. He was then sent to Afghanistan for seven months. Everyone clearly states that he came back a different person from the Lionel Desmond who left home. He experienced exposure to the extremes of death and suffering in war during his time in Afghanistan as well as serious physical ailments that included his reports of serious concussions and back injuries. There is repeated documentation of his suffering from post-traumatic stress disorder and related mental

[6] Example in the Desmond case were his perception/obsession that his wife was unfaithful and exploiting him financially.

health problems. He was actively seeking help for his mental health disorders and distress until the very end.

Shanna's mother reported that the couple lived in Oromocto, NB for several years while Lionel was in the CAF. Shanna returned to NS to study nursing and began working at a hospital in Antigonish. In March 2016 the couple stayed with Shanna's mother in Upper Big Tracadie while looking to get their own home. Lionel's mother would come visit in the winter. Reportedly the couple got along well before he started experiencing the impact of his deployment through his PTSD symptoms. According to his sister Cassandra, Lionel helped support Shanna through nursing school for four years as she had to travel back and forth between provinces for her education. Chantel Desmond reported that the couple did not reside in the same residence for years and described them as "basically kind of separated"; they had a home in NB which they sold a few months prior to the tragedy. There were reports of repeated separations and a potential divorce for at least 7 years. In January of 2017, divorce seemed imminent. A friend described Lionel as packing up to leave Shanna and "being on a rampage" the day before the homicides. Just before the tragedy, Lionel reached out for counselling and changed his request from couples' counselling to individual therapy. Shanna reached out to a shelter for information about a peace bond and family court processes to protect her daughter. Neither was assessed as high priority in terms of risk in terms of what they communicated to helping agencies in the weeks and months leading up to January 3, 2017. A thorough review of their history at that point would suggest otherwise.

There were many warning signs over the years about domestic violence in the relationship between Lionel Desmond and Shanna. Often the term domestic violence or abuse were not used and several other terms which would be euphemisms to minimize the problem would be used such as conflict, marital problems, arguing, snapping, verbal altercations, interpersonal conflicts, relationship issues' outburst and anger. Some of these words may have been accurate at certain points in time but overall, these words did not capture the depth of the problems and the escalating risk of violence over time. There were many concerning incidents and behaviours which suggested a serious pattern of domestic violence over the years. These concerns were minimized to some extent by a focus on mental health problems and PTSD rather than domestic violence. An important finding in my review is that the focus on mental health overshadowed the reality of domestic violence and family, friends and professionals involved tended to ignore the domestic violence or not recognize that there were 2 distinct, albeit overlapping problems: mental health and domestic violence.

Some examples of this concerning behaviour are outlined in this section. Lionel's sister Cassandra said he kept accusing Shanna of cheating on him. Shanna's mother reported that Lionel became jealous and had dreams of her being unfaithful and killing her. Family members including Shanna's mother and Lionel's sisters reported that he put many details of his relationship with Shanna on Facebook that were concerning – especially in the context of his mental health problems. Shanna's mother reported that Shanna told him to get help because he was scaring Aaliyah as he would go around the house banging and hitting things. Cassandra indicated she did not hear them fight in front of others but did recall an argument between them in the past year

with Lionel saying to Shanna, “I’m not leaving Aaliyah here to be raised by you guys” and indicated a desire to take Aaliyah back to NB with him. Shanna’s sister reported that she did not feel Shanna was fearful of Lionel “because we became so used to him acting out”. Shanna’s sister recalled an incident where police were called to the house by Shanna and removed Lionel’s guns. According to Shanna’s mother, when Lionel got angry “it was like demons coming out of him” because of a different look on his face. Lionel’s sisters had seen his varying moods and witnessed him lose his temper as well as make threats over minor issues.

Other concerning examples included: Shanna’s father reported that Lionel used to “go off” and his treatment did not appear to help him. He reported that the couple had “little arguments” that did not get out of hand when he was present. Shanna’s father reported that Shanna purchased a new truck because Lionel took the truck from her, and she had to miss a weekend of work; her father reported he gave her money for a down payment on the truck. Cassandra reported that when the couple had their disputes on one of Lionel’s “off days” Shanna would come and get his mother as a support for Aaliyah. There were multiple reports of a permanent separation and divorce. There were multiple reports of violent dreams/domestic homicide including Lionel saying he had a dream about cutting off Shanna’s head. Chantel reported that Lionel “went crazy”/ “had a little fit” because he put Shanna’s new truck in the ditch after a New Year’s Eve get-together. Their mother reported this to Chantel and indicated “I’m only there to help Aaliyah” when Chantel advised her to mind her own business. Chantel thought that Shanna “kicked him out” after that last incident.

There were several warning signs as the marriage appeared to be falling apart. These signs included: Chantel reported that she “knew something was up” as Lionel had been distant over the past few months. Chantel reported that Shanna took a loan of $15 000 which contributed to the couple’s problems. Chantel reported that Lionel “just snapped” because he wanted to work things out, but Shanna did not want to work things out anymore. Chantel reported that Lionel was staying with his aunt for a few days prior to the incident; reportedly the aunt was worried about him that day. Chantel reported that Lionel was “always jealous towards his wife and controlling a vulgar tongue towards my family.” The extended family systems would have seen chronic marital difficulties and escalating risks with Lionel. Shanna was fearful enough to call the RCMP about his mental health problems and identified that he should have his weapons removed. She told a family doctor in November 2015 that her husband was aggressive, angry and manic” but there was no follow-up. She shared some threatening text messages with her sister and her sister even received one from Lionel that said, “let he know I got eyes on a 22 magnum”.

Shanna was trying to help her husband get his mental health needs addressed and appeared to be his advocate. At some point in January 2017, Shanna must have decided she couldn’t manage the situation anymore and divorce and a safety plan for her daughter seemed to be the priority based on her call to Nicole Mann at the shelter (Naomi Society). Lionel’s mother told others that she was there to protect her granddaughter. Shanna’s mother and sister reported that Shanna, Aaliyah, and Brenda were all increasingly frightened by Lionel. All the evidence points to the fact

that Brenda Desmond died trying to protect Aaliyah and Shanna as well as trying to help her son as he appeared to become more desperate about his life.

Cpl. Desmond's presentation appeared complicated to his family and professionals trying to help him. Within his marriage and family, he could appear to be frightening when he became angry and was triggered by relatively minor incidents. He acknowledged to professionals that he frightened his wife and daughter. He appeared to deny the seriousness of his violence and suicidal behaviour when confronted by professionals. It is not clear if he is lying or minimizing or forgot what he did. In one text from September 2015 Shanna write her sister that he "needs help but won't tell them the whole story". When Shanna is interviewed by mental health professionals, she clarifies many issues and the level of paranoid thinking or misinformation that her husband had presented. She reports patterns of abuse including serious harassment through texting and Facebook[7]. There are texts that are alarming to others such as her message to her sister that he "wants to kill all of us". Some of these issues are critical to the treatment of abusers and holding them accountable for what they are doing and the impact it is having on their wife and children. An additional problem was the many faces of Cpl. Desmond. Before the homicide, he is reported to attend church and be his normal self as he was visiting some friends and family. Even in the purchase of the weapon used in the homicides, he was a thoughtful and polite customer that caused no alarm. He could control his behaviour at times but not consistently in his father and husband role. This speaks to a hallmark of domestic violence as an issue to be addressed independent of any mental health disorder.

Warning Signs from Professionals

From my review of the file there were at least 40 professionals in Quebec, New Brunswick and Nova Scotia who had some contact and documented concerns about Cpl. Desmond beginning in 2011. These professionals including staff members from the CAF/VAC, multiple social workers, psychologists, psychiatrists, case managers. Cpl. Desmond had extensive reports both on an in-patient basis as well as community assessments. The police were involved on multiple occasions dealing with his suicidal ideation and disclosures to his wife that raised concerns about his access to firearms. It was shocking that any professional would think he should have a firearm license in the context of all the available information about the risks he presented. In the 2 years leading up to the domestic homicides-suicide, there were multiple reports expressing significant concerns about Cpl. Desmond's declining mental health and increasing stressors in his family, finances and living circumstances. In my opinion, Cpl. Desmond may not have been released from his last hospitalization and/or there would have been an urgent safety plan and risk management strategy put in place had all the information from 2011-2017 – especially reports between January 2015 and 2017 - been accessible to the medical professionals that had contact with him in his final months of life.

[7] The Quebec records indicate that his possessive texting: e.g., she checked text in the morning and two-three hours later her break there were 83 messages. Another time, he was texting through the night, she woke up to over 400 texts (many nasty), texting at least one per minute sometimes two per minute. She suggests that we ask to see his phone to look at what he wrote and timeline.

The extent to which Cpl. Desmond's life was spiraling downhill is best exemplified by the Canadian Armed Forces in their transition to civilian life interview. CAF uses a risk indicator tool to measure and monitor a veteran's "probability of successful transition, reestablishment, and rehabilitation". As of May 2015, Cpl. Desmond scored in the moderate risk category for an unsuccessful transition into civilian life[8]. By January 2016 – a year before the homicides-suicide, his score was in the high-risk category. By the time Cpl. Desmond prematurely left the stabilization unit at Ste. Anne's Hospital on August 15, 2016, he is anything but stable. All his mental disorders seem aggravated and the paranoia and stress from his marriage falling apart seem to be at a peak. He leaves with no plan as to where to stay and how he can manage all the stressors he is facing. There are outstanding needs including planning for a "neuropsychological assessment will be part of formal recommendations as further insight in his cognitive functioning" that is highlighted in their report.

From 2011-2017, no one really addressed the extent of domestic violence and abuse. Most professionals did not explore what was really happening between Cpl. Desmond and his wife – as well as what their daughter was living with in these circumstances. Most professionals used multiple euphemisms to describe the issues in the marriage – conflicts, marriage problems, separation, potential divorce, anger, aggressive, paranoid, financial conflicts, problems with the in-laws, verbal disputes, resentment, tensions in the family, reacting strongly, and marital distress. Some professionals described very serious concerns that were red-flags and foreshadowed the ultimate tragedy. These included comments such as "fears he might hurt someone", "fleeting homicidal thoughts", "nightmare of violence", "Shanna Desmond feared he might hurt himself or someone else", "paranoid thoughts about his wife's infidelity", "heightened sensitivity to rejection", "dreams of his wife cheating on him and attacking her and her lover", "daughter frightened by him", "violence towards objects", "nightmare of chopping his wife to pieces", "angry, aggressive, manic" and escalating arguments "triggered by his anger" and his trauma symptoms.

In my file review, I found several common misunderstandings about domestic violence that were exhibited by the professionals and service systems involved with the Desmond family. In my opinion, these misunderstandings undermined the potential for better assessments of the serious risks and appropriate interventions required. The terms violence and abuse were rarely used or expanded upon in interviews with both Lionel and Shanna Desmond. The problem was not named. There was a focus on mental health alone and not the impact of Cpl. Desmond's suicidal behaviour and other symptoms on his wife and daughter. His suicidality was a potential risk for both himself and for others in his life and there needed to be more done to manage risk to all involved. There were times and people who seemed to manage Lionel's problems better than others and he needed to recognize how his behaviours and emotions impacted the well-being of his wife and daughter. Suicide threats as a form of domestic violence and coercive control is not named.

[8] The severity of the problems is noted in the VAC transition interview (2015-05-25) in that he faces a host of problems upon his release from the CAF for medical reasons including separation from his wife and daughter. Desmond "advises that he is having anger and intimacy issues with his spouse".

The domestic violence issues are never thoroughly addressed, and Shanna's perspective is not sought other than the phone conference with her near the point of discharge from St. Anne's Hospital in Quebec. When she seems to take charge during a hospital assessment near the end, there seems to be no understanding or analysis of her desperation and the context of the couple's lives. When the topic of abuse is approached, it is focused on physical abuse rather than recognizing multiple form of domestic violence. The couple is expected to describe the extent of what is happening and the risks rather than seeing that as the role of a professional doing a risk assessment. The focus is on suicide risk alone rather than on homicide risk and ongoing domestic violence. Half of all domestic homicide victims don't see the risk because they are just surviving or trying to manage/help the perpetrator. The perpetrator may be dropping hints but generally has little appreciation of the impact of his behaviour on others. The presenting problems is seen as either mental health or domestic violence and not both problems. In this case the extensive nature of both problems compounds the issues and elevates risk together with multiple other factors (separation and divorce, child custody issues, financial problems, housing, and employment).

None of the professionals involved consider the need for specialized domestic violence program for abusers as a complement to other treatments. There is a lack of concern by professionals on the safety of the couple's daughter who was living with domestic violence and exposed to severe marital conflict and adult issues. The one exception appears to be a report from Cpl. Desmond's CAF social worker, Ms. Zandra Pinette to NS Family & Children's Service in November 2015 to relay Cpl. Desmond's concerns about the maternal grandfather. There are no records to suggest any substantial investigation was launched. There would have been extensive information available in seeking the insights of the extended family system. Aaliyah seems invisible in any of the professionals' assessments but her mother and paternal grandmother express concerns to others about her safety. Shanna's mother and sister report the escalating fear of Shanna, Aaliyah, and Brenda in trying to manage Lionel. He is even turning on his daughter when she is trying to be supportive. There appears to be a lack of professional education on the impact of domestic violence (or even marital discord, paternal mental health, separation) on children.

Risk Factors from Review of Inquiry Evidence

Based on the concerning incidents and reports outlined above from family and friends as well as the professionals involved in counselling or mental health interventions, there were multiple risk factors. Only a few individuals addressed the domestic violence in Cpl. Desmond's relationship with Shanna. Others involved noted that it was a marriage in distress and there were long-standing concerns about his worries/delusions about her fidelity. Ironically, he acknowledged his own infidelities to her and even to their daughter but continued to accuse her of the same without any evidence. Shanna was rarely interviewed alone for her perspectives. At Ste. Anne's Hospital in Quebec, the couple couldn't even mange a joint session without extreme anger being exhibited. There was evidence that some of Cpl. Desmond's concerns about finances and infidelity had no basis in fact. Near the end Shanna was interviewed with Lionel at St. Martha's Regional Health Centre which could limit her ability to be frank about her personal safety in his presence. She also had just begun a job there which would make full disclosure difficult. Other

than calls to the police about suicide threats and firearms concerns, Shanna did not appear to be reaching out for help until the very end when she sought information from the Naomi Society about a peace bond and child custody issues on an anonymous basis.

In reviewing the evidence from the Inquiry, Cpl. Desmond presented with 20 risk factors associated with domestic homicide based on the 41 factors outlined in the field and utilized by the Ontario Domestic Violence Death Review Committee. The Ontario committee considers 7 factors or more to be classified as a homicide that appears to be predictable and preventable with hindsight. In the Desmond case, the factors and evidence for them are summarized in Table 1. The evidence from the Inquiry supporting the risk factors identified can be found in Appendix B. All 41 factors and their definitions can be found in Attachment B.

The major risk factors deal with multiple warning signs that have been reported by one or more sources of information during the Inquiry. Some factors are static (always there such as childhood history of abuse) and some factors are dynamic (changing circumstances like a marital separation or plans for a divorce). The risk factors are summarized in Table 1 and outlined briefly in this paragraph. Cpl. Desmond reported "severe verbal and physical abuse"[9] in his childhood which is a risk factor for later domestic violence. He was going through a marital separation that seemed to be part of a repeated cycle over many years but now appeared more final with Shanna asking for a divorce. He was unemployed and very discouraged by these circumstances. He was struggling with Post Traumatic Stress Disorder and depression – these disorders were so severe and long-standing that they were diagnosed several times by mental health professionals and the profound symptoms were visible to friends and family. He had coped in the past through alcohol misuse. Cpl. Desmond repeatedly spoke of suicide and had made specific threats about how he was going to kill himself. He sent threatening texts to Shanna and her sister as well as posted concerning FB messages. There are reports in his hospital records of prior attempts at suicide. He had required police intervention in the past to remove his weapons. He was constantly jealous of his wife and accused her of infidelities even though there appeared to be no basis to these claims. Whether they were delusions or genuinely held beliefs due to his insecurities, they were a significant risk factor. There was a prior history of domestic violence and threats against others. He threatened to kill his father-in-law. He had fantasies and dreams he shared on how he might kill his wife. He had tried to strangle her in his sleep during a nightmare. He attempted to be controlling regarding access to the family vehicle, froze her bank account, and in the past, expressed concern about her studies to become a nurse.

Other risk factors included his access to weapons and knowledge on how to use them from his military training. He was also suffering from significant physical injuries related to his reported past concussions during his military service as well as back pain. He experienced significant sleep issues. He had erectile dysfunction which compounded the intimacy issues and his worries about infidelity. He had been a victim of racism in the CAF and had been distressed over how his disclosures were handled. He was under a great deal of stress due to financial concerns (potential

[9] He repeats this concern in several psychiatric and psychological assessments. However, family members never acknowledge or address this issue.

bankruptcy) and the need for housing after separation (he expressed an intention to look for government housing). Cpl. Desmond appeared unable to make an adjustment back to civilian life after his time in Afghanistan and all the things that gave him a sense of pride and accomplishment seemed to be slipping away. In the words of a VAC report a year before the tragedy; "he has lost all sense of normalcy".

Table 1

Risk factors Identified prior to Desmond Homicides-Suicide

RISK FACTORS
Perpetrator History
• Perpetrator was abused and/or witnessed DV as a child
Family/Economic Status
• Actual or pending separation • Perpetrator unemployed • Potential child custody and access dispute
Perpetrator Mental Health
• Excessive alcohol and/or drug use by perpetrator • Depression – in the opinion of family/friend/acquaintance and/or professionally diagnosed • Other mental health or psychiatric problems – perpetrator • Prior threats to commit suicide by perpetrator • Suicide attempts in the past
Perpetrator Attitudes/Harassment/Violence
• Obsessive behavior displayed by perpetrator • Sexual jealousy • Prior destruction or deprivation of victim's property • History of violence outside of the family by perpetrator • History of domestic violence - Current partner/victim • Prior threats to kill victim • Prior threats with a weapon • Controlled most or all of victim's daily activities • Choked/strangled victim in past
Access
• Access to or possession of any firearms
Victim's Disposition
• Victim's intuitive sense of fear of perpetrator
Other Factors
Perpetrator had serious physical problems related to concussions and a back injury, sleep problems were severe, erectile dysfunction, he also was dealing with racism from CAF, financial and housing concerns as major stressors, long-standing problems in readjustment to civilian life, medication compliance

The risk factors listed in Table 1 accumulated until the time of the homicides-suicide in January 2017. There were multiple missed opportunities for interventions related to domestic violence that was clearly a major aspect of this case. There had been no specialized assessments that had fully considered Cpl. Desmond's domestic violence or the needs of his wife and daughter. No specialized domestic violence services were offered to them (other than a RCMP officer suggesting victim service or Naomi Society). The entire focus was on the mental health problems and the PTSD and even those problems were treated by multiple professionals who did not share the information and history on a timely basis up to the tragic end.

There may have been some assumptions that as a victim Shanna Desmond needed to reach out earlier and often for help. She disclosed concerns to the police and mental health professionals that could have been the subject of a further assessment. She told a family doctor that he was "aggressive, angry and manic". There were mixed views in the family regarding their observations of domestic violence and the extent to which police or other interventions would be required. There were indicators that some hoped that prayer would help, and others felt that the family should stay out of the couple's business. There were some safety concerns about protecting their daughter. Shanna Desmond did reach out regarding the suicide threats and access to weapons, but the matter should have been red flagged at that point for follow-up and separate interviews with her and him. There could have been a "warm handoff"[10] to victim services rather than just providing a business card. From the evidence gleaned from her comments to others I would make some observations about Shanna that are consistent with my experience and knowledge in the field. I believe that she was trying to manage a difficult situation without enough external resources. Like half of homicide victims, she may have seen the danger her husband presented to himself but not to herself and her family. She may have not wanted to end the relationship until he was properly on his feet, but his condition was deteriorating. After the events of New Year's day, it appeared that she decided she couldn't manage the situation any more.

Calling the police and developing a safety plan were needed actions, but she may have worried that the only answer would be his incarceration and another low point that would contribute to her husband's downward spiral. She might not have wanted to do that to him or to their daughter. As well, given her African Nova Scotian ancestry in a rural community, the idea of an outside police intervention may not have been welcomed and she may have feared that a bad situation would get worse. At the same time, she was starting out as a nurse at a local hospital, and she may have been concerned that her private business would be known quickly throughout the community if it wasn't already. As a nurse she may have considered herself in a caretaker role with her husband and felt responsible to do things to help him as she tried to do during their final hospital visit.

[10] The term "warm handoff" is used several times during the Inquiry evidence and suggests a more active connection between a professional providing service and a referral to another service. An example might be a police officer calling victim services on the phone and explaining concerns directly with the victim beside them including risk factors – and even handing over the phone to set up an initial appointment.

CONCLUSIONS & RECOMMENDATIONS

The January 2017 triple homicides and suicide committed by Cpl. Desmond that took the lives of his wife Shanna, their 10-year-old daughter Aaliyah, and his mother Brenda seem entirely predictable and preventable with hindsight. This hindsight is clear in the context of all the information available about the serious risks that Cpl. Desmond was presenting and the history that could have been known to professionals as well as family and friends. Although it may have been difficult to predict exactly when and how these events would unfold, Cpl. Desmond and his family seemed on a clear path for a horrific tragedy based on all the available information reviewed by the Inquiry.

In all, there were at least 40 professionals working within health, mental health, CAF/VAC, and policing who would have had exposure to aspects of the stressful circumstances and accumulating risks that Cpl. Desmond was presenting. There were multiple disclosures that should have raised significant concerns about a potential suicide and/or homicide. Cpl. Desmond was desperately seeking help in the years leading up to this tragedy and was still trying to make an appointment for counselling just before the end.

By the time of the tragedy, the following major risk factors had been documented:

- Serious suicide threats by Cpl. Desmond
- Dreams and fantasies of homicide
- Repeated separations and talk of a final split and divorce
- Ongoing domestic violence and constant jealousy and obsession that his wife was unfaithful to him with no basis in fact
- Harassment and threatening texts to Shanna and concerning Facebook postings
- Serious mental health problems related to PTSD and depression and a search for a successful intervention up to the tragic end
- Concerns about the well-being of his daughter and talk of a custody dispute
- Exposure to domestic violence for his daughter
- Serious physical disorders related to the reported concussions and back injuries
- Growing desperation about employment, economic circumstances, and access to housing

One of the critical observations I would make is that each risk factor and incident that brought it to light (i.e., disclosure to friends, family, professionals) was treated as an individual event rather than as part of a broader context of the ongoing history of the situation. Every event needed to be considered in the context of the length and depth of this couple's difficult history and the alarming patterns of behaviour. For example, his presentation at hospital for psychiatric consultation near the end was limited by the lack of access to all the prior assessments and attempts at intervention. The focus became whether he said he had intentions or plans to kill himself or others that day. The focus should have been on his alarming history and accumulated risk factors to that point. Each new service provider should have been aware of the mountain of risk factors to deal with if they had had access to prior assessments and could have coordinated with previous service providers.

The purpose of this review and the function of an Inquiry are ultimately to find ways to prevent a tragedy of this kind in similar circumstances in the future. It is not to lay blame on professionals or various helping systems but rather understand the training and policies that could be enhanced or developed to prevent a similar tragedy. Surviving family members usually feel guilt about missed opportunities to do or say something – this report and recommendations are not intended to add to that burden but rather shine a light on how to save future victims. Although these homicides are exceptional events, one death is one too many and there are too many to ignore. Most importantly the literature in the field of domestic violence/homicide as well as the risk factors outlined above suggest that most of these homicides do not happen out of the blue but rather follow a course of well-known incidents and risk markers. The following recommendations are offered for the Inquiry's consideration in reflecting on the evidence heard to date.

1. Expand Public Education on Domestic Violence and Domestic Homicide – Including the Impact on Domestic Violence on Children – Neighbours, Friends, Family and Co-Workers

The Nova Scotia government has several existing initiatives related to domestic violence prevention and public education that need to be expanded to reach a broader audience. The provincial government through the Advisory Council on the Status of Women and multiple Ministries is developing a provincial plan (see Standing Together to Prevent Domestic Violence https://novascotia.ca/standingtogether/). There are public education initiatives for victims, perpetrators as well as friends, families and neighbours that should be expanded to recognize the diverse context of domestic violence including rural communities and African Nova Scotians (https://women.novascotia.ca/womens-safety/safety-planning).

Social norms are changing, and domestic violence is increasingly considered everyone's business but often friends, family, neighbours, and co-workers are hesitant to get involved. Reluctance to get involved reflect widely held views. These views are even stronger in rural communities. People are hesitant to get involved and even if they do, they often don't know what to say or do – or worry they will make things worse. The answer lies in extensive public education programs on the dangers of domestic violence and how to support victims, perpetrators, and their children. These programs need broad circulation in the community and need to be reinforced through public service announcements with champions in multiple NS communities to spread the message. A passive website is not as effective as training champions, utilizing social media and finding spots to promote the message during highly subscribed TV show (e.g., Hockey Night in Canada – here is an example from an PSA during a Montreal Canadians French Broadcast on Réseau des SportsRDS - https://www.youtube.com/watch?v=ICcRb6qXxi0). Some critical themes for public education are outlined below.

- Promote broader public awareness about the risk of lethal violence for women and children living with domestic violence, particularly at the time of a pending or actual parental separation. Information on how to support a "safe" separation should include safety measures for adult victims and their children.

- Suicide threats during a separation are a significant red-flag and may be a form of domestic violence in themselves.
- Challenge the culture of silence surrounding domestic violence and its apparent acceptance in many families. Learn how and when to speak with victims and perpetrators about these concerns.
- Work to understand and reflect diverse realities including those of rural communities and African Nova Scotians in training for professionals and public education campaigns.
- Educate about the availability of domestic violence resources and how to access them. Don't assume that a 'one size fits all' approach will be effective. Be mindful of including resources that are appropriate for specific communities.
- Promote an understanding the role of police including the importance of contacting police immediately and report their concerns when they are aware of individuals who have potential access to firearms and who are in a relationship where domestic violence is suspected. This is particularly important when the couple is going through a separation, or the individual is showing signs of depression or suicidal or homicidal thoughts.
- Include information such as online resources, brochures, and public presentations, about ways to contact police or victim services for advice and support in non-emergency situations.
- Ensure that public education campaigns address the increased risk for domestic homicide when there co-exists a history of domestic violence and the presence of mental illness in a perpetrator. The campaign should stress the seriousness of the risk posed by an individual with a mental disorder who is threatening to harm his/her partner and/or is threatening self-harm.
- Make the potential links between domestic violence and post-traumatic stress disorder. These links should be part of a public and professional education campaign for military personnel, family members and professionals providing treatment for military personnel.
- The impact of exposure to domestic violence on children needs to be highlighted and a recognition of the potential emotional and physical harm to them.
- Use workplaces as a pathway to reach the majority of adults in Nova Scotia with public education programs on identifying and responding to the risk factors of domestic violence.

2. Expand Professional Education on Domestic Violence and Domestic Homicide – Including the Impact on Children

Ensure that frontline professionals in multiple systems such as health, mental health, education, social services, and the justice system are up to date with current information about domestic violence, the dynamics in these relationships, the impact of domestic violence on children and the potential for lethality in these cases. Part of being up to date is the awareness of risk factors, risk assessment, safety planning and risk management strategies.

Professional education and training across sectors should include the following elements:

- Awareness about domestic violence and the dangers inherent for victims, perpetrators, and their children. Awareness of the common risk factors for intimate partner homicide that have been identified in research across Canada should be highlighted.

- Screening for lethality and risk assessments (or referral to experts in the area) focused on domestic violence. There is a need to have appropriate assessment tools available to those who work with victims and perpetrators of domestic violence to better assess the potential for lethal violence in their lives. Correspondingly, once the risk is identified, victims and perpetrators of domestic violence need access to appropriate services and programs.

- Understanding how to work with perpetrators of domestic violence and the critical importance of speaking with victims to help overcome the likelihood of the perpetrators minimizing and denying the abuse.

- Understanding that when a mother/parent is at risk of lethality then children may also be at risk.

- How to reach out and collaborate with the police and justice system for advice on potential lethal situations when there is a documented history of concern.

- Risk management with perpetrators and safety planning for victims in the prevention of repeat domestic violence and domestic homicides. Special emphasis should be placed on the impact that depression has on domestic violence and domestic homicide.

- The presence of risk factors such as access to firearms and depression should trigger risk assessment, safety planning and risk management with patients/clients as potential perpetrators/victims.

- When an individual is diagnosed with depression, efforts should made by the mental health professionals to encourage families to remove the individual’s access to firearms with police assistance if needed.

- Mental health professionals who engage in screening for risk of suicide should include risk of homicide in cases with a history of prior domestic violence and separation. All

healthcare providers should be mindful of the dynamics of domestic violence and the potential for lethality, especially when working with patients who have a history of alcohol and/or drug abuse, depression, anxiety, or suicidal ideation. When domestic violence is identified in the patient's life, the potential for lethality should be assessed by the healthcare provider, or the patient should be referred to others with an expertise in making such assessments. The significance of prior perpetrator suicide attempts or threats should be emphasized in domestic violence training and education as a risk factor in forecasting the prospects of future lethal harm to not only themselves, but also others.

- Risk assessment should include collateral information from all relevant sources, including family, friends, police, and other agencies, with respect to the potential risk to the woman and her children posed by the perpetrator's behaviour. Concerns about any risks to children should be reported to children protection services.

- All front-line professionals that deal with individuals and families in crisis should adopt an appropriate risk assessment process and a mechanism or protocol at a local and interprovincial level to facilitate and enhance communication between agencies and professionals when a person is identified to be at risk. For example, such a protocol should permit any professional evaluating a high-risk case to contact the local police service's case manager or domestic violence coordinator to establish a case conference to ensure appropriate tracking and response to the case. Professionals in all sectors should know about the NS High-Risk Case Coordination Protocol.

- Professionals in every sector should be aware of the specialized services for victims, perpetrators of domestic violence and their children and the specialized services for victims, perpetrators of domestic violence and their children should amplify their efforts to share information about their work in the health and mental health sector. Community conferences need to be held to enhance cross-training and collaboration amongst these service providers and embracing the existing NS high-risk protocols.

- To educate the next generation of practitioners, The NS Deans or Chairs of Departments of Social Work, Psychology and Medicine should ensure courses are provided on domestic violence and risk assessment and risk management. Reviewing the Inquiry Report should be required reading.

- Regulating bodies and Professional Associations for these professional groups should provide ongoing professional development on domestic violence and highlight the major findings and recommendations from this Inquiry. These Regulating bodies and Professional Associations include Nova Scotia Board of Examiners in Psychology; Nova Scotia College of Social Workers; Nova Scotia College of Counselling Therapists; College of Physicians and Surgeons of Nova Scotia.

3. Police Risk Assessment and Service Coordination

Nova Scotia has responded to past murder-suicides with a clear commitment to enhance police training in responding to domestic violence as well as to improve coordination across justice and all human services[11]. Nova Scotia has a model framework – The High-Risk Case Coordination Protocol that is supposed to be put in place across the province. Since its inception in 2004, there have been no homicides in cases that have followed this protocol and there are current efforts to augment this work with the Highest Risk Table in domestic violence cases to further these efforts[12].

It is clear from the Desmond Inquiry evidence that there were missed opportunities to utilize this protocol. Cpl. Desmond represented a high-risk case that needed to be flagged and enhanced coordination efforts were required among the police, victim services, social services, mental health and health care professionals. There were multiple police calls related to concerns about Cpl. Desmond's firearms to the RCMP in the 14 months leading up to this tragedy. Shanna Desmond stated in one call that "harm may come, not sure to him or someone else" and police were told about the depth of the mental health problems and explicit suicide threats. Shanna had asked about the peace bond process and the RCMP gave her a victims' service referral card (November 28, 2015; RCMP report). She was described as reluctant but said she would follow through on her own time. There was a subsequent incident involving Cpl. Desmond yelling at his father-in-law on his property trying to locate his firearms that had been removed. Approximately 6 weeks before the homicides, Cpl. Desmond called that he had been "kicked out of his house and their marriage was over". RCMP saw no need for police action.

Several recommendations come to mind in reviewing these police interventions. The recommendation include:

A provincial audit to make sure that the high-risk protocol is being used and officers have the training to recognize high-risk circumstances which may require a review of the history as well as reaching out to collateral sources of information. One could easily speculate that this protocol may be more challenging in rural areas and the RCMP may have less specialized officers covering a larger geographic area compared to larger urban centres like Halifax.

It may be timely for the NS Departments of Justice and Community Services to review and update the high-risk protocol to deal cases in which there is no criminal offence but there is concerning behaviour related to the intimate partner (e.g., concern about weapons, knowledge and access

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[11] "The Department of Justice and the Department of Community Services internal reviews into the deaths of Lori Lee Maxwell and Bruce Allan George (September 8, 2000) and the external Russell Review into the Framework For Action Against Family Violence (May 31, 2001) highlighted the importance of comprehensive case coordination in relation to incidents of domestic violence". (see https://www.novascotia.ca/just/publications/docs/russell/summary.htm and http://vawforum-cwr.ca/sites/default/files/attachments/highriskframework.pdf

[12] Singer, V. (2021, June 11-14). Preventing domestic homicide: From research and lived experiences to practice: Service Providers Perspectives in Domestic Violence Risk Assessment, Safety Planning and Risk Management. London ON Virtual Conference. https://www.youtube.com/watch?v=S48YJxIMpy0

to weapons, threats to hurt themselves, intuitive fear about others, mental health history, separation, or decision to divorce, conflict with other family members).

Part of the above suggested review could be province-wide training for police and community partners on an updated protocol that reviews lessons learned from this Inquiry. An important topic to include is working with reluctant victims who may need to be engaged on the level of risk they face and the different interventions that may be possible. The issue of racism and the challenges for African Nova Scotian or other minority groups to reach out to police would be essential.

4. **The NS Department of Community Services, Family and Children's Service conduct an internal lesson learned review of the missed opportunity to intervene with the concerns about Aaliyah's safety from the VAC social worker.**

Family and Children's Service received a report in November 2015 regarding concerns about Aaliyah's safety from Cpl. Desmond related to the maternal grandfather. A thorough investigation would have raised many red flags about Cpl. Desmond and the ongoing concerns about mental health and domestic violence. This referral may have been a missed opportunity to focus on Aaliyah and her needs.

5. **The Canadian Armed Forces and Veterans Affairs Canada should ensure that high risk cases are red flagged for immediate follow-up, prioritization of resources, appropriate information sharing with community partners and close monitoring.**

The summary report from the Inquiry with a link to the full report should be shared with all military personnel involved in services for veterans to highlight concerns about mental health, domestic violence, and high-risk reintegration into the community. The last 2 years of Cpl. Desmond's life were filled with him reaching out repeatedly for assistance and finding either slow or incomplete responses to his well-documented needs in a high-risk situation. There was a lack of flexibility in engaging his family in counselling and difficulty accessing resources that may have assisted him. There was a lack of information sharing and coordination of services in a circumstance that demanded the highest level of care. There are many lessons to be learned that need to be shared.

There are many issues highlighted in recommendation #2 on educating professionals which would apply to those working on behalf of veterans with the CAF/VAC. There needs to be more in-depth understanding of domestic violence as outlined above. Some specific recommendations that follow from this tragedy would include:

- Active engagement and support of family members who are trying to support the veteran including coping with his mental and physical condition(s)
- Recognizing that suicide risk may also include homicide risk for a partner dealing with separation and multiple stressors

- Recognizing risk to children living with domestic violence and engaging the child protection system when needed to help protect children and support a protective parent
- Working closely with the veteran's home community and services available so they are fully informed about past assessments and intervention efforts – ideally a case conference or a "warm handoff" so that local professionals have all the information required to keep the veteran and their family safe and adjusting to life after deployment.
- Recognizing PTSD, suicidal ideation, and a pending separation or divorce as a good time to express concern about access to weapons and support weapons being kept away through appropriate provincial authorities.

6. Integrating Domestic Violence Prevention into Schools for Universal Access to Information for Children and Adolescents

The Desmond Inquiry has highlighted an extensive lack of knowledge and understanding about domestic violence in the general public and professionals from multiple sectors. This finding has implication for how we better educate the next generation. One aspect of prevention is educating young people about this topic in childhood and adolescence as a normal part of their elementary and secondary school education and complementary community programs[13]. There is also a need to educate teachers and school staff about warning signs, the plight of children living with domestic violence and potential reporting responsibilities (e.g., https://www.learningtoendabuse.ca/our-work/pdfs/TeacherHandbook1.pdf).

I do not have up to date information about the extent to which NS schools currently integrate this information in teacher professional development and lesson plans in the regular curriculum. A starting point would be a review of this area. It should be noted that there are many existing programs that provide information about healthy relationships and the dangers of abuse within intimate relationships. This information is critical for both victims, perpetrators, teens living with violence as well as their peer group who may have opportunities to intervene and encourage help-seeking. These are lifelong lessons. This recommendation is not to simply create new programs as an add-on for educators but rather integrate these ideas into existing classes such as health and physical education as a requirement for all students. For examples including existing programs in NS please see https://healthyrelationshipsforyouth.wordpress.com/about/, https://www.redcross.ca/how-we-help/violence-bullying-and-abuse-prevention/educators/healthy-youth-dating-relationships , https://youthrelationships.org/.

[13] https://www.learningtoendabuse.ca/our-work/pdfs/Report-Crooks_Jaffe-Primary_Prevention_VAW_Update.pdf; Crooks, C. V., Jaffe, P., Dunlop, C., Kerry, A., & Exner-Cortens, D. (2019). Preventing gender-based violence among adolescents and young adults: lessons from 25 years of program development and evaluation. Violence against women, 25(1), 29-55.

7. The Creation of a Nova Scotia Domestic Violence Death Review Committee

This Inquiry is shining a spotlight on how multiple systems responded to a high-risk complex situation with multiple needs related to mental health, firearms, and domestic violence. In the months ahead another inquiry – the Mass Casualty Commission will be examining many overlapping issues related to the April 2020 mass shooting in Nova Scotia with a mandate that includes examining the role of gender-based and intimate partner violence, access to firearms, and prior interactions and relationship of the perpetrator with the police (https://masscasualtycommission.ca/about/mandate/). Public and professional interest in how to prevent these tragedies will be heightened. The focus on domestic homicides should not end with this Inquiry and there will be a need for an ongoing review of all domestic homicides through a domestic homicide review committee. Ideally, the Nova Scotia government will provide funding through the Chief Medical Examiner to develop an interdisciplinary committee to review all domestic violence deaths that borrows from the experience of other Canadian committees. There has already been some discussion about having an Atlantic provinces death review committee outlined in recent testimony which should be encouraged as a funding priority[14].

8. The Need for a Provincial Implementation Committee

In my experience, the Desmond Inquiry is one of the most comprehensive and thorough inquiries into this subject matter ever held. One of the shortcomings with any inquiry is that when the public attention is gone from these hearings, that the impetus for change may dimmish over time. Few of the recommendations can happen overnight. In fact, most of the recommendations being considered will take years to implement and require extensive collaboration across different government ministries working together. To ensure that recommendations are not lost with the passage of time, it would be helpful to have a formal implementation committee made up of senior government officials from different ministries involved with regular reporting and audits related to successful implementation. Some liaison or partnerships with federal government departments such as Veterans Affairs Canada will also be required. At a minimum, it would be helpful to plan for a 5-year period for this committee.

SUMMARY COMMENTS

I trust that this report and recommendations are helpful for the Inquiry. From reviewing all of the transcripts, it is painfully clear that these deaths have had a devastating impact on the community – not only family and friends of the deceased but also professionals who would be left to wonder what they could have done differently. My report is not intended to reinforce any survivor or professional guilt or self-blame but rather focus on the future and how such a tragedy could be prevented in similar circumstances in the future. Nova Scotia has an opportunity to be a leader in Canada in learning from this tragedy. As indicated above, the Inquiry may want to consider an ongoing provincial audit and implementation committee to ensure that these efforts lead to

[14] Testimony of Ms. Stephanie MacInnis-Langley, Executive Director of the Nova Scotia Advisory Council on the Status of Women, September 14, 2021.

significant and sustainable changes so the insights gathered provide guidance and meaningful changes for years to come.

I would be pleased to expand on my analysis and recommendations in my testimony.

Respectfully submitted

Dr. Peter Jaffe Ph.D., C.Psych.
Senior Consultant
Director Emeritus
London Family Court Clinic

Professor Emeritus
Western University
London ON Canada

APPENDIX A - MATERIALS REVIEWED

Expert Witness Package Document List

1. **Royal Canadian Mounted Police**
    1. Index - Royal Canadian Mounted Police document

Exhibits (36 documents)

1. 18-A (Police report)
2. 31 (Police occurrence summary)
3. 32 (Police supplementary occurrence report)
4. 33 (General report)
5. 34 (General report)
6. 81 (Open Source Intelligence Brief)
7. 82 (hand written notes and occurrence summary)
8. 83 (Supplementary occurrence report and disclosure to firearms officer)
9. 84 (email)
10. 86 (occurrence details)
11. 87 (occurrence details)
12. 88 (occurrence details)
13. 89 (Len MacDonald request for disclosure)
14. 99-A (Extraction report)
15. 99-B (phone log report)
16. 99-C (email log)
17. 99-D (email log)
18. 99-E (email log)
19. 99-F (cell phone text log)
20. 99-G (cell phone text log)
21. 99-H (cell phone text log)
22. 99-I (cell phone text log)
23. 99-J (cell phone text log)
24. 99-K (Samsung browser log)
25. 99-L (cell phone text log)
26. 99-M (cell phone text log)
27. 99-N (cell phone text log)
28. 99-O (cell phone text log)
29. 99-P (cell phone text log)
30. 99-Q (cell phone log)
31. 99-R (cell phone text log)
32. 99-S (cell phone log)
33. 99-T (cell phone log)
34. 99-U (email log)
35. 99-V (cell phone log)
36. 99-W (cell phone/email log)

Testimony (7 documents)

1. Cpl Gerard Rose-Berthiaume
2. Staff Sgt Addie Maccallum
3. Cst Burns Anderson
4. Cst Steven Richard
5. Cst Leonard MacDonald
6. Civilian Member Sean Hughes
7. Civilian Member Gilles Marchand

2. St Martha's Regional Hospital

1. Index - St Martha's Regional Hospital

Exhibits (9 documents)

1. 67 (St. Martha's Regional Hospital Materials)
2. 69 (medical record)
3. 71 (psychiatric consultation)
4. 72 (support letter)
5. 105 (Mental Health & Addiction Policy and Procedure)
6. 108 (psychiatrist note and med list)
7. 109 (medical list including Ortho, pediatrics, OB etc.)
8. 110 (patient and apt. log)
9. 113 (mental health & addictions crisis response service & MH Risk/assessment form)

Testimony (11 documents)

1. Dr Justin Clark
2. Dr Faisal Rahman-February 4 2020
3. Dr Faisal Rahman-February 5 2020
4. Dr Ian Slayter
5. Heather Wheaton-February 10 2020
6. Heather Wheaton-February 11 2020
7. Lee Anne Watts
8. Maggie Mary MacDonald
9. Ellen MacDonald
10. Amy Collins
11. Joan Hines

3. Nova Scotia Community Healthcare Professionals

1. Index - Nova Scotia Community Healthcare Professionals

Exhibits (5 documents)

1. 76 (psychotherapy assessment form)
2. 77 (text message)
3. 92 (Guysborough Medical Clinic release of records)
4. 283 (Clinical Care Manager Outcomes Agreement)
5. 288 (BHSOL Online Provider Application Checklist)

Testimony (6 documents)

1. Dr Ranjini Mahendrarajah
2. Dr Ali Khakpour
3. Dr Luke Harnish
4. Catherine Chambers-February 12 2020
5. Catherine Chambers-February 13 2020
6. Helen Luedee

4. Canadian Armed Forces

1. Index - Canadian Armed Forces

Exhibits (64 documents)

1. 136 (Request for Tertiary Investigation)
2. 183 (Psychiatric Assessment Sept 28, 2011)
3. 184 (letter from psychiatrist Oct 28, 2012)
4. 185 (Psychiatric Assessment Sept 25, 2013)
5. 186 (medical examination Oct 22, 2014)
6. 187 (Scan-Intermed Complexity Assessment Interview Questionnaire Nov 18, 2013)
7. 188 (Psychiatric Progress Report Oct 5, 2011)
8. 189 (Psychiatric Progress Report Oct 27, 2011)
9. 190 (Psychiatric Progress Report May 3, 2012)
10. 191 (Psychiatric Progress Report Jun 6, 2012)
11. 192 (Psychiatric Progress Report Jul 31, 2012)
12. 193 (Psychiatric Progress Report Oct 2, 2012)
13. 194 (Psychiatric Progress Report Nov 6, 2012)
14. 195 (Psychiatric Progress Report Dec 13, 2012)
15. 196 (Psychiatric Progress Report Feb 27, 2013)
16. 197 (Psychiatric Progress Report Mar 27, 2013)
17. 198 (Psychiatric Progress Report Apr 4, 2013)
18. 199 (Psychiatric Progress Report May 7, 2013)
19. 200 (Psychiatric Progress Note May 28, 2013)
20. 201 (Psychiatric Progress Note Jun 6, 2013)
21. 202 (Psychiatric Progress Note Jun 20, 2013)
22. 203 (Psychiatric Progress Note Jul 18, 2013)
23. 204 (Psychiatric Progress Note Aug 28, 2013)
24. 205 (Psychiatric Progress Note Oct 10, 2013)
25. 206 (Psychiatric Progress Note Nov 12, 2013)
26. 207 (Psychiatric Progress Note Nov 19, 2013)
27. 208 (Psychiatric Progress Note Jan 7, 2014)
28. 209 (Psychiatric Progress Note Feb 18, 2014)
29. 210 (Psychiatric Progress Note Apr 17, 2014)
30. 211 (Psychiatric Progress Note Jun 19, 2014)
31. 212 (Psychiatric Progress Note Jul 17, 2014)
32. 213 (Psychiatric Progress Note Sept 3, 2014)

33. 214 (Psychiatric Progress Note Oct 20, 2014)
34. 215 (Psychiatric Progress Note Dec 2, 2014)
35. 216 (Psychiatric Progress Note Feb 18, 2015)
36. 217 (Psychiatric Progress Note Apr 16, 2015)
37. 218 (Psychiatric Progress Note Jun 16, 2015)
38. 219 (Protected B Document Jan 27, 2012)
39. 220 (Psychology Progress Note Feb 9, 2012)
40. 221 (Psychology Progress Note Feb 23, 2012)
41. 222 (Psychology Progress Note Feb 19, 2013)
42. 223 (Psychology Progress Note Sep 10, 2013)
43. 224 (Nurse Case Management Note Apr 13, 2015)
44. 225 (Dependency Assessment May 20, 2015)
45. 226 (Discharge Summary Jun 13, 2016)
46. 227 (email Sep 16, 2013)
47. 228 (Psychiatric Progress Note Oct 20, 2014)
48. 229 (Psychiatric Progress Note Feb 18, 2015)
49. 230 (Psychiatric Progress Note Apr 16, 2015)
50. 232 (Psychology Progress Note Dec 1, 2011)
51. 233 (Psychology Progress Note Feb 9, 2012)
52. 234 (MO Progress Note Apr 26, 2012)
53. 235 (Allied Note Sep 10, 2012)
54. 236 (Psychology Progress Note Oct 11, 2012)
55. 237 (Psychology Progress Note Nov 15, 2012)
56. 238 (Psychology Progress Note Nov 29, 2012)
57. 239 (Protected B document Feb 26, 2013)
58. 240 (Allied Note Sep 25, 2013)
59. 241 (email Sep 27, 2013)
60. 242 (Protected B document May 13, 2015)
61. 251 (Medical Examination Record)
62. 252 (Protected B document Oct 29, 2013)
63. 300 (Protected B document Feb 4, 2015)
64. 301 (Protected B document Apr 13, 2015)

Testimony (2 documents)

1. Dr Vinod Joshi
2. Dr Wendy Rogers

5. <u>New Brunswick OSI Clinic</u>

1. Index - New Brunswick OSI Clinic

Exhibits (1 document)

1. 244 (Health Record Documents)

Testimony (2 documents)

1. Dr Mathieu Murgatroyd
2. Dr Anthony Njoku

6. <u>New Brunswick Community Healthcare Professional</u>

1. Index - New Brunswick Community Healthcare Professional

Exhibits (6 documents)

1. 140 (medical records)
2. 144 (Protected B document Oct 29, 2013)
3. 145 (Protected B document Oct 29, 2013)
4. 146 (Protected DGMC, A and B documents)
5. 148 (Protected B document Jan 14, 2015)
6. 150 (Protected B document Jan 14, 2015)

Testimony (2 documents)

1. Dr Paul Smith-February 24 2020
2. Dr Paul Smith-February 25 2020

7. <u>Ste Anne's Hospital</u>

1. Index - Ste Anne's Hospital

Exhibits (7 documents)

1. 254-pp 6-7 (Dr note in French)
2. 254-pp 13-17 (Discharge Summary in French)
3. 254-pp 41-49 (Psychiatric report in French)
4. 254-pp 79-90 (Nurse Data Collection)
5. 254-pp 238-306 (Progress Notes)
6. 254-pp 350-365 (Occupational and Group Therapy notes)
7. 255 (Social Services convo with Shanna)

Testimony (6 documents)

1. Dr Robert Ouellette
2. Dr Isabelle Gagnon
3. Kama Hamilton
4. Julie Beauchesne
5. Maria Riccardi
6. Julie Blondin

8. <u>Marie-Paule Doucette, Veterans Affairs Canada</u>

1. Index - Marie-Paule Doucette, Veterans Affairs Canada

Exhibits (5 documents)

1. 117 (Case Plan)
2. 273 (summary of services for provider)
3. 278 (Transition Interview)

4. 291 (Area Counsellor Client-Centred Assessment 2016-01-05)
5. 292 (Client Initiated Screening)

Testimony (2 documents)

1. Marie-Paule Doucette-June 22 2021
2. Marie-Paule Doucette-June 23 2021

9. Family and Historical Information

1. Index - Family and Historical Information

Exhibits (18 documents)

1. 77 (text msg about apt.)
2. 162 (audio statement of Cassandra Desmond Jan 5, 2017)
3. 164 (audio statement of Kenny Greencorn Jan 5, 2017)
4. 165 (audio statement of Chantel Desmond Jan 3, 4, 2017)
5. 167 (audio statement of Ricky Borden Jan 4, 2017)
6. 168 (Affidavit of Ricky Borden sworn Jan 26, 2021)
7. 169 (audio statement of Thelma Borden Jan 4, 2017)
8. 170 (Affidavit of Thelma Borden sworn Jan 26, 2021)
9. 171 (audio statement of Shonda Boparai Jan 5, 2017)
10. 175 (text msg Arp 23, 2016)
11. 176 (text msg continued)
12. 177 (cell phone screen shot Nov 8, 2016)
13. 178 (screen shot continued with photo)
14. 179 (screen shot of text msg Nov 25, 2016)
15. 180 (screen shot of text msg Nov 25, 2016 continued)
16. 181 (screen shot of text convo with Shanna)
17. 182 (screen shot of text convo)
18. 285 (screen shot of text msg to Sasha Dec 2, 2016

Testimony (13 documents)

1. Shonda Boparai-Borden-February 19 2021
2. Shonda Borden-June 21 2021
3. Sheldon Borden
4. Ricky Borden-Affidavit
5. Thelma Borden-Affidavit
6. Cassandra Desmond
7. Chantel Desmond
8. Paul Long
9. Albert Junior MacLellan
10. Orlando Trotter
11. Diane Desmond
12. Kaitlyn Desmond
13. Kenneth Greencorn

10. Domestic Violence and Firearms

1. Index - Domestic Violence and Firearms Purchase

Exhibits (4 documents)

1. 78 (Naomi Society phone call log)
2. 79 (audio statement of Nicole Mann Jan 4, 2017)
3. 112 (USB-Gun Shop Video)
4. Transcribed Statement Kulanek-Daniel

Testimony (2 documents)

1. Mann-Nicole
2. Kulanek-Daniel

11. Risk Factors - Domestic Violence (2 documents)

1. DV Risk Factors - New Brunswick
2. DV Risk Factors – Quebec

12. DV Risk Factors – Quebec (3 documents)

1. Working Desmond Timeline
2. New Brunswick OSI Timeline - Court Copy
3. Quebec Timeline - Court Copy

13. Report from Department of Community Services - Family and Children's Services – Recording November 23, 2015

14. Testimony on NS Family Service and Domestic Violence Services

1. Ms. Nancy MacDonald, Executive Director of Family Service of Eastern Nova Scotia (September 15, 2021).
2. Ms. Stephanie MacInnis-Langley, Executive Director of the Nova Scotia Advisory Council on the Status of Women (September 14, 2021).

APPENDIX B – DVDRC RISK FACTORS WITH LIONEL DESMOND

Risk Factor	Description
Perpetrator History *Perpetrator was abused and/or witnessed DV as a child*	• Perpetrator reported verbal and physical abuse in childhood as reported by psychiatrist in Canadian Armed Forces document (Exhibit 183, pg. 3)
Family/Economic Status *Actual or pending separation*	• As per the perpetrator's sister's report, Shanna wanted to end the relationship and kicked him out a few days prior to the homicide (pg. 7, Exhibit 18-A) • Kenneth Greencorn said that the perpetrator told him he was getting a divorce (pg. 17 of same exhibit); • St. Martha's Hospital records noted a temporary separation (Exhibit67, pg.24)
Perpetrator unemployed	• Perpetrator was no longer working in the military, as per Thelma and Ricky Borden's report (pg. 22, Exhibit 18-A) • St. Martha's Hospital Records by psychiatrist indicated he was unable to work and had financial issues (Exhibit 67, pg. 27)
Child custody and access dispute	• Repeated references to divorce and concerns about care of daughter
Perpetrator Mental Health *Excessive alcohol and/or drug use by perpetrator*	• St. Martha's Hospital records indicate prescribed marijuana, and past alcohol abuse which stopped in 2016 (Exhibit 69, pg.2) but also self-references to relapses • Perpetrator stopped marijuana use in 2016 as per testing of Dr. Slayter (pg. 61) • NB OSI Clinic notes in 2015 indicated he drank 3 beers/day and felt it could become problematic (Exhibit 244, pg. 9); • perpetrator reported coping by abusing alcohol (6 beers per day) as per NB OSI Clinic notes (exhibit 244, pg. 79)

Depression – in the opinion of family/friend/acquaintance and/or professionally diagnosed	• perpetrator spent the night at a hospital complaining of a recent non-violent altercation with his wife and indicated that he was feeling depressed (Jan 1, 2017). He was released the next morning - St. Martha's Hospital, as per police records (pg. 27, Exhibit 18-A) • A history of the perpetrator's depression reported by Shanna to police (Exhibit 82, pg. 1) • St. Martha's Hospital Records indicated the psychiatrist reported a diagnosis of major depression (Exhibit 67, pg. 27)
Other mental health or psychiatric problems – perpetrator	• PTSD, as reported by his sister, Chantel Desmond (Exhibit 18-A, pg. 6) • possibly diagnosed with schizophrenia, as per Shonda Borden (pg. 20, same exhibit); • additional bipolar diagnosis, as per Thelma Borden (pg. 23 of same exhibit); • his aunt called police and Shanna requested a wellness check, indicating he was in a manic state (Exhibit 31) • police records indicate he had been detained under provincial mental health legislation for an occurrence related to his PTSD on Nov 27, 2015 (pg. 3, Exhibit 87) • St. Martha's Hospital records by psychiatrist indicate diagnosis of "Post Traumatic Brain Disorder" related to 3 concussions in addition to PTSD, as well as "ADD" and "borderline delusions re Wife" (Exhibit 67, pg. 27); "anxiety/situational crisis" noted in testimony of Dr. Clark (pg. 37) • perpetrator exhibited obsessive compulsive traits as reported by psychiatrist in Canadian Armed Forces document (Exhibit 184, pg. 3) • As reported by Thelma Borden, Shanna told her that he said that if he couldn't

	have his daughter, he would be in a body bag (pg. 23 of Exhibit 18-A)
Prior threats to commit suicide by perpetrator	• Supplementary occurrence report indicated perpetrator had threatened to hurt self and others in the past (Exhibit 32) • On November 27, 2015, police notes indicated Shanna called and reported that the perpetrator was making suicidal comments. He was hospitalized voluntarily then released (Exhibit 82, pg. 1) • victim reported texts with suicidal intonations (Ste Anne's Hospital records, Exhibit 255, pg. 2)
Attempts at suicide	• reports of suicide attempts with shotgun 5 years earlier (Ste. Anne's Hospital record)
Perpetrator Attitudes/Harassment/Violence *Obsessive behavior displayed by perpetrator*	• Victim reported obsessive texting (Ste Anne's Hospital records, Exhibit 255, pg. 2)
Sexual jealousy	• As per his sister's report, perpetrator would accuse Shanna of cheating when off his medication (pg. 7, Exhibit 18-A) • St. Martha's Hospital Records by psychiatrist indicated he had "borderline delusions" of jealousy regarding wife (Exhibit 67, pg. 27)
Prior destruction or deprivation of victim's property	• Perpetrator broke table (testimony of Dr. Clark, pg. 67) • perpetrator threw drawers around his room (St. Anne's Hospital records, Exhibit 255, pg. 1)

History of violence outside of the family by perpetrator	• assault against father-in-law as reported by CAF psychiatrist (Exhibit 209, pg.1)
History of domestic violence - Current partner/victim	• Perpetrator choked Shanna while having a dream (pg. 20, Exhibit 18-A) • Perpetrator was known to "go off" (pg. 13, Exhibit 18-A) • Statement from Kenneth Greencorn indicated that perpetrator told him he had a dream of cutting victim's head off (pg. 17 of same exhibit). • In text msg exchange between them, victim claimed he was physically abusive (pg. 478, Exhibit 99-G). • Victim alleged name calling in text message history between her and the perpetrator (page 8, Exhibit 99-S) • Police testimony indicates perpetrator texted the victim, apologizing for putting his hands on her (testimony of Cpl Gerard Rose-Berthiaume, pg. 92) • Hospital records indicate perpetrator had history of anger management issues and longstanding interpersonal conflicts with wife. He had a verbal altercation with the victim who asked him to leave the home (St. Martha's Hospital, Exhibit 108, pg. 1) • "Frequent outbursts at home" reported by perpetrator in hospital (Testimony of Ellen MacDonald pg. 14) • perpetrator reported relationships issues to Helen Boone, social worker and CCM(exhibit 283, pg. 1)
Prior threats to kill victim	Text messages – "He wants to kill all of us" "Let her know I got eyes on a 22 magnum"
Prior threats with a weapon	• Perpetrator threatened to kill father-in-law, as per his sister's report (Exhibit 162, pg. 22)

Controlled most or all of victim's daily activities *Choked/strangled victim in past*	• Perpetrator froze victim's bank account in an effort to control her spending (New Brunswick medical records, pg. 17, 23, 52) • Choked victim while having a dream (pg. 20, Exhibit 18-A)
<u>Access</u> *Access to or possession of any firearms*	• Perpetrator used a firearm to commit the homicide-suicide as per police report. He had a firearms license. He purchased a firearm January 3. (pg. -8-9, Exhibit 18-A) • Kenneth Greencorn said that perpetrator had guns, although he thought he had sold them (pg. 17 of same exhibit)- some thought he was not allowed to have access to guns (e.g. Catherine Hartling, pg. 25 of exhibit) (firearm license was under review as of Dec 2015, but reinstated as per police notes, (Exhibit 82, pg. 1)); it appears perp owned 3 guns (as per police notes, Exhibit 84, pg. 1)
<u>Victim's Disposition</u> *Victim's intuitive sense of fear of perpetrator*	• Shanna expressed fears to family and increasing concern about managing his behaviour. • Police testimony of Cpl Gerard Rose-Berthiaume (pg. 36-37) indicated that victim likely spoke to Nicole Mann from Naoimi Society in Antigonish, a DV centre in relation to going through a separation from husband who had mental health issues and "domestic issues" in the past (but reportedly did not feel threatened by any at that time) • note from Naoimi Society indicated victim had called asking for info on a Peace Bond due to perpetrator's MH issues and concerns for their daughter, although she did not feel daughter was unsafe with him (DV Exhibit 78) • statement from Nicole Mann at Naoimi indicated victim asked if child could be

	named in peace bond (statement of Nicole Mann in Exhibit 79)
Other Factors	• as per Thelma Borden, perpetrator suffered a head and back injury while in the military and "had problems ever since" (pg. 23, Exhibit 18-A); • Supplementary occurrence report indicated perpetrator had stopped taking medications (Exhibit 32) • Perpetrator talked about financial struggles - intent to look into government housing, bankruptcy, food bank (in text messages provided in police exhibits) • St. Martha's Hospital records indicate perpetrator had challenges readjusting to life as a civilian and navigating VA (Exhibit 67, pg. 8) • Perpetrator experienced sleep issues due to back injury as per report of Catherine Chambers (Exhibit 76, pg. 2) • Perpetrator was deemed unfit to operate a weapon (NB Community Health, Exhibit 145, pg. 1)

APPENDIX C – SELECTED REFERENCES

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ForenPsyCorp Inc.
P. Scott Theriault, BSc, MD, FRCPC
Founder, Forensic Psychiatry, RCPSC

October 17, 2021

Honorable Judge Warren K. Zimmer
Nova Scotia Provincial Court

Your Honour,

RE: LIONEL DESMOND
Date of Birth: November 21, 1983; Date of death: January 3, 2017

Professional Qualifications

I am a duly qualified medical practitioner licensed to practice psychiatry in the provinces of Nova Scotia and New Brunswick, and I have a consultant license in Prince Edward Island.

I completed my undergraduate education at Dalhousie University, completing a BSc in chemistry and then going on to complete my MD degree at Dalhousie in 1986. Following completion of a residency in psychiatry at Dalhousie in 1991 I became a member of the Royal College of Physicians and Surgeons of Canada.

I completed a fellowship in forensic and correctional psychiatry at Queen's University in 1997/98 and have practiced as a forensic psychiatrist since that time. In 2011 I was given the special designation of Founder of Forensic Psychiatry, which was then becoming a recognized sub-speciality, by the Royal College of Physicians and Surgeons.

I am an Associate Professor of Psychiatry at Dalhousie University and hold the position of Clinical Director for Mental Health and Addictions, Central Zone, Nova Scotia Health Authority.

Introduction

I have been asked by Mr. Allen Murray, QC, lead counsel for the Desmond Inquiry and Mr. Shane Russel, Co-Counsel, to review the case of Mr. Lionel Desmond through the lens of a psychological autopsy.

The Desmond fatality inquiry is held pursuant to the Fatality Investigations Act by order of the Minister of Justice and Attorney General, dated 14 February 2018. As noted in the Ministerial Order:

"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;
b. the cause of death;
c. the manner of death; and
d. circumstances under which the death occurred including

- i. *the circumstances of Lionel Desmond's release from St. Martha's Hospital on January 2, 2017;*
- ii. *whether Lionel Desmond had access to appropriate mental health services, including treatment for occupational stress injuries*
- iii. *whether Lionel Desmond and his family had access to appropriate domestic violence intervention services;*
- iv. *whether health care and social service providers who interacted with Lionel Desmond were trained to recognize the symptoms of occupational stress injuries or domestic violence;*
- v. *given Nova Scotia 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;*
- vi. *what restrictions, if any, applied to accessing federal health records of Lionel Desmond by provincial health authorities and personnel; and*
- vii. *any recommendations of the judge about the foregoing matters.*

The concept of a psychological autopsy developed in the 1950s from the work of Los Angeles County Chief Medical Examiner – Coroner Theodore Curphey, M.D., and Dr. E. S. Shneidman, Co-Founder of the L.A. Suicide Prevention Centre. At the time, the Los Angeles County's Coroner's Office was dealing with a number of drug related deaths of an equivocal nature utilizing the so-called NASH system (N-natural, A-accidental, S-suicide; H – homicide).

Dr. Shneidman wrote "*In essence, the psychological autopsy is nothing less than a thorough retrospective investigation of the intention of the decedent – that is, the decedent's intention relating to his being dead – where the information is obtained by interviewing individuals who knew the decedent's actions, behavior, and character well enough to report on that matter"*[1].

Readers of this report are advised that some areas of the inquiry are outside of the scope of my review. My focus is on clinical and psychiatric aspects related to Mr. Desmond and some areas of interest to the inquiry, such as Mr. Desmond's acquisition of firearms, access to medical

[1] Leenaars, A. The Psychological Autopsy. Routledge 2017

records, and problems with communication and/or coordination between care providers are not part of this review.

Sources of Information

I have been kindly provided by Inquiry staff with voluminous information concerning Mr. Desmond, both in hard copy and electronically. A list of materials reviewed can be found as Appendix A to this report. I have attached, for the Court's reference, a copy of my CV as Appendix B.

Further information concerning Mr. Desmond was obtained not only by review of source materials but through review of witness testimony, and as suggested by the above definition of psychological autopsy, through telephone interviews with key individuals. In particular, I have had the opportunity to conduct telephone interviews with Ms. Cassandra Desmond, Mr. Desmond's sister; Ms. Thelma Borden, Ms. Shanna Desmond's mother; and Corporal Orlando Trotter, personal friend of Lionel Desmond.

Brief Review of Events of January 3, 2017

A relatively concise accounting of the events of the 3rd of January 2017 can be found in the general report from the RCMP (Exhibit # P000018-A). That report notes "*At 1810 hours on 2017/01/03, Sgt. MacCallum was in office continuing duty after shift when OCC dispatched a 911 call from a female named Chantelle, who advised that there was a possible suicide in progress at 15375 Highway 16, Upper Big Tracadie. Sgt. MacCallum and Cst. Sparks began to head to the scene when updated that it was a possible murder/suicide as Lionel Desmond and wife, Dana Desmond, were dead in the house. Sgt. MacCallum was aware that this residence and associated family members were well known to police with calls related to violence.*

Approximately 5 minutes later OCC advised that a John Day called back to say he had entered the house, first finding one more deceased then another; a total of four deceased and there was a gun involved.

... Sgt. MacCallum spoke with a hysterical female later ID'd as Chantelle Desmond, who was screaming that her family was all dead and she called police. Sgt. MacCallum then spoke with male later ID'd as John Day, who stated he was Chantelle's husband. They just got a phone call to come to the house. He had gone inside and found the family dead. Looks like Lionel shot them. He stated he touched a few of them to check. Back up members were still 10-15 minutes away."

Police entered the residence and *"Sgt. MacCallum made way through dining room to an open set of French doors. Sgt. MacCallum could hear voices from inside and cut the angle of the doorway and saw an adult black female (subject 1) laying in a pool of blood just inside the kitchen to the left of the French doors. The female appeared to have a gunshot to her head and appeared dead. Moving further through the doorway Sgt. MacCallum observed a black adult male (subject 2) laying on his back just to the right of the first female. The male had an apparent gunshot wound to his head that had destroyed most of his head and was obviously dead. The male was dressed in full green camouflage clothing. A long-barreled carbine was laying on his torso, with the magazine missing. Sgt. MacCallum felt that he recognized the male as Lionel Desmond. ...A third subject, a black adult female (subject 3) was observed crumpled against the kitchen wall/door in a large pool of blood a short distance to the right of the deceased male. She appeared to be dead. Writer then noticed a fourth victim, a small black female child (subject 4) lying face down on the carpet floor in the living room in front of the TV. A small dog was sitting beside her."*

Police noted that the third and fourth victims were "*very warm*". The four victims were identified as Lionel Desmond, his wife Shanna Desmond, Lionel Desmond's 10-year-old daughter, Aaliyah, and Lionel Desmond's mother, Brenda Desmond.

Police were able to confirm that Mr. Desmond purchased a firearm from the "*Leaves and Limbs Outpost*" gun shop in Antigonish. The police general report notes police interviewed the gun shop owner Danny Kulanek "*who stated that Lionel Desmond had been in his store on Tuesday, January 3 at around 4 p.m. and bought a 767 cal SKS firearm with a scope along with a pack of 50 .767 cal bullets. Kulanek provided a copy of the receipt for the purchase and a video of Lionel Desmond inside the gun shop. Kulanek stated that Lionel Desmond had a valid firearms license to purchase the firearm and that he left the gun shop with the firearm in a box'.*

In the audio statement that Mr. Kulanek gave to police on January 4, 2017, he reports that Mr. Desmond bought the more expensive ammunition for the weapon, was wearing a long coat and described Mr. Desmond as "*well mannered, well dressed. He was very polite and he wasn't loud. He was well spoken and just a casual, relaxed customer.*".

Police obtained a statement from Mr. George Desmond, brother of Brenda Desmond, and note that around 6 pm on January 3, 2017, "*His sister Brenda called him and told him to "get down here as fast as you can, that boy just shot his wife. Lionel. He just shot her. He has a gun.*".

Lionel Desmond

Henry David Thoreau once wrote "*Not that the story need be long, but it will take a long while to make it short.*". Mindful of this, I will try to provide as concise and accurate an accounting of

the life of Lionel Desmond, including his developmental history, relationship history, and clinical interactions and interventions as possible.

Mr. Desmond's early developmental history is obtained from a review of files and from my interview with Ms. Cassandra Desmond.

Mr. Lionel Desmond was one of five children born to his parents. Mr. Desmond was the only male in the family and has four sisters; Diane, Cassandra, Chantelle, and Kaitlyn. Mr. Desmond was raised in Lincolnville, a small, rural, predominantly black African Canadian community in rural Nova Scotia.

Mr. Desmond was raised in a large extended family in a household that included not only Mr. Desmond and his siblings but his aunt and her children, various cousins, and Mr. Desmond's maternal grandfather and grandmother. Mr. Desmond's biological father does not appear to have been part of the family and very little is known about him or any related physical or psychiatric history. Ms. Cassandra Desmond, on questioning, indicated that as far as she is aware there is no family history of any psychiatric issues.

There are some discrepancies in the description of Mr. Desmond's early formative years. Ms. Cassandra Desmond painted the family's early years, including her brothers', in a generally positive light, indicating that she "wouldn't change it for the world". She indicated the household was sometimes hectic and crowded due to the number of people living there and indicated that all the children were taught "right from wrong" which at times could include a "slap on the bum or hand".

This characterization stands in contrast to others, such as the assessment from Dr. Ian Slater, dated December 2, 2016 (P-000071), in which he notes "*He describes his childhood growing up in Lincolnville, NS as "tough". He grew up in an extended family. He was vague with regard to details. Discipline was strict but he was not abused.*".

Similarly, in a report dated September 28, 2011(P-000183), from Dr. Joshi, psychiatrist with the Department of National Defense, Dr. Joshi notes "*Cpl. Desmond describes his childhood as difficult. He experienced severe physical and verbal abuse. He denies any history of sexual abuse. Cpl. Desmond did not do well in school. He managed to complete grade 12. He denied any problems during schooling years.* ".

With respect to this latter issue, Dr. Slater, in his assessment, indicated that Mr. Desmond "*struggled in school*". However, in my conversation with Ms. Cassandra Desmond, she indicates that she has no recollection of her brother struggling in school but does note that he was a very active youth and was "go go" all of the time.

Ms. Desmond indicated that her brother completed high school in 2001 and initially planned to become a mechanic. He joined the Canadian Armed Forces in 2004.

All three interviewees were consistent in describing Mr. Desmond's character during his youth and early adulthood. His sister described him as "the funniest person ever, always ready with a

joke". She described him as social and energetic ("go go") and did not report any difficulties with anger or mood lability ("not moody"). Ms. Thelma Borden indicated that Mr. Desmond was a "joking, loving" guy. Mr. Desmond's friend, Orlando Trotter, indicated that his early recollections of Lionel Desmond were that he was a "funny person" who was "kind, spirited" and "happy". Cpl. Trotter, who was on the same unit as Mr. Desmond in the military, indicated that pre deployment Mr. Desmond had no difficulties getting along with others.

As noted in the affidavit of Thelma Borden (P-000170), Shanna Borden began to date Lionel Desmond when she was 16 years of age, and he was approximately 18. Cassandra Desmond indicated that the family, or at least some members of the family, were not particularly happy about the relationship, as it turns out that Shanna Borden and Lionel Desmond were related (third cousins). Ms. Cassandra Desmond also expressed some concerns about Shanna's father Ricky's "rap sheet"; apparently, he has a criminal history.

Ms. Desmond indicates that for a period of time Lionel Desmond and his mother stopped talking to one another because of the acrimony this issue caused. Ms. Desmond indicates that when Shanna became pregnant with their daughter, Aaliyah, he decided to join the military to provide for the family. Aaliyah was reportedly only a few weeks old when Lionel Desmond was deployed. When he returned from deployment the plan was that he be married immediately in a formal wedding, but Mr. Desmond failed to attend; they were later married in a civil ceremony, a cause for further consternation amongst the extended family.

There is considerable documentation throughout the file and from the comments given to me by Cassandra Desmond and Thelma Borden that there remained ongoing difficulties between the two families such as Cassandra Desmond's comment to me that when visiting home in Nova Scotia, the Borden side of the family actively kept him away from his family; or Thelma Borden's comment that with respect to his siblings, Lionel Desmond had "cut them off" because of "the way they treated their mother".

I raise this, not to judge the veracity of either side, but only to suggest that as a result, Mr. Desmond did not have a balanced, widespread base of family support.

As noted above, Mr. Desmond joined the Canadian Armed Forces in 2004 in part, according to his sister, to provide stability for his family. In 2007, Mr. Desmond was deployed to Afghanistan for seven months.

In my discussion with Cpl. Trotter, he indicates that following deployment he noted some subtle changes with his friend. He indicates that Lionel Desmond would "go quiet" sometimes for several days at a stretch and then would "come around". He indicates that he believes that this was his friends' attempt to "process what was happening".

Cpl. Trotter indicated that when the unit was brought back, that his friend appeared to be "struggling". He indicates that they "broke up the team" and Mr. Desmond was placed with the "pipes and drums". He indicates that he believes his friend felt increasingly isolated. He also indicated that he became more complaintive about the people that he was working with, sometimes suggesting racism was involved.

Mr. Desmond was first seen for a psychiatric assessment on September 28, 2011 (exhibit P-000183). Dr. Joshi, the attending psychiatrist, notes under chief complaint "*Cpl. Desmond presents with first episode for the last three and a half to four years duration of not feeling very well. He reports a change in his personality, not able to go out of the house, not able to go into crowded places such as malls. He hasn't been to a grocery store for a very long period of time. He is not able to sleep well. He experiences recurrent nightmares, including sweating. He remembers incidents in Afghanistan, especially about carrying body bags and many other incidents that he witnessed. He is isolating himself and has lost motivation or interest to contact family or friends. He feels emotionally detached. He experiences increased anger outbursts and irritability. He has flashes of reliving experiences from overseas. Cpl. Desmond decided to seek help at the persuasion of his wife.*"

Dr. Joshi provided a diagnosis of posttraumatic stress disorder with major depressive episode. Cpl. Desmond, who was on Effexor (an antidepressant) had the dose increased by Dr. Joshi and he was started on Risperdal (an antipsychotic) and Prazosin (Minipres, used for sleep and to suppress nightmares). In an update, dated October 28, 2012, to the senior district medical health officer with Veterans Affairs Canada in Saint John, New Brunswick (P-000184), Dr. Joshi notes "*When reviewed in late spring and early fall of 2012, he continues to have significant problems with PTSD symptoms. They have gotten worse by his wife deciding to separate from him. Cpl. Desmond continues to attend psychotherapy. His long term prognosis is guarded in light of poor response to treatment until October 2012*".

Records show that Dr. Joshi continued to follow Mr. Desmond into 2015. He was also treated with psychotherapy by Dr. Wendy Rogers and had ongoing visits with a nurse practitioner. During this period of time, he was treated with Effexor, Risperidone and Zopiclone (a hypnotic) and the diagnosis of PTSD and depression was maintained.

In reviewing Dr. Joshi's handwritten notes over that period of time, it appears that Lionel Desmond had an up and down course. Some of this seemed to relate to external stressors, such as work stressors, ongoing relationship issues with respect to his wife, and anxiety about his release from the military. Dr. Joshi's handwritten note of 16 April 2015 (P-000230) reads "*Not doing very well. Stressed about upcoming medical release. Planning to put house on sale. His wife is not very communicative about her intentions to stay with him or separate. Financial concerns +. No SI/HI.*"

Dr. Joshi notes under recommendations "*Referral to OSI clinic for continuing case*". Mr. Desmond was referred to the OSI clinic in a referral dated April 16, 2015. Mr. Desmond was discharged from the Canadian Armed Forces in June of 2015.

Mr. Desmond was seen for a telephone triage appointment on May 7, 2015 (P-000244, pg. 81), just prior to his discharge. The assessing nurse notes "*Client expressed a decline in his mental health and stressors concerning his release next month. Client stated he has night sweats, low mood and still concerns with his sleep. His wife has remained in school NS for the past six years and he stated they tend to argue a lot, causing the long distance relationship to be strained. He plans on putting his home up for sale this week and will move to NS once he sells it. The client*

expressed a desire to return to therapy and see psychiatry. Currently client is taking medical marijuana, 1 gram/day as well as other medications. He stated he has a follow up appointment with Dr. Smith in July. Patient denies SI/HI but states he has increased his drinking to daily and is concerned it could be problematic."

Mr. Desmond was seen for his first regular appointment with his new psychologist, Dr. Murgatroyd on June 24, 2015(P-000244, pg. 80). Mr. Desmond reported to Dr. Murgatroyd a *"recent surge in anxiety and stress led to an increase in alcohol consumption and said he was going through approximately two 24-packs of beer per week" ... he began to see an addictions counselor...Since then, he said his drinking has slowed down but he still consumes approximately five beers per day.*"

Mr. Desmond reported ongoing PTSD symptoms, including night sweats, intrusive thoughts, and symptoms of low mood and anhedonia (decreased interest in pleasurable activities). Dr. Murgatroyd saw Mr. Desmond for 10 sessions between his first appointment and May 9, 2016. Records also show that Mr. Desmond had a number of phone contacts with Dr. Murgatroyd over that period of time, as well as several missed appointments.

Mr. Desmond saw a psychiatrist, Dr. Njoku, on August 31, 2015(P-000244, pg. 33). Dr. Njoku, under Impression, notes "*My impression was that he was still very severely suffering from his PTSD symptoms, which don't really seem to have relieved much or perhaps have further exacerbated following release. He did make homicidal threats but it appears from his previous notes this on and off has been a feature with him without any evidence he'd ever acted on it. He, however, wasn't suicidal and has no previous history of suicidal acts either. His mood appeared depressed and he was very anxious today. Overall, I was concerned about his presentation, not sufficient for him to be formally admitted involuntary to the hospital though while at least enough to believe he would really benefit from a residential treatment. On discussing this, however, he was very hesitant and not prepared to consider it much.*"

Dr. Njoku provided a diagnosis of "*chronic PTSD, quite severe. Major depressive disorder. Comorbid alcohol use disorder*". Dr. Njoku also noted that Mr. Desmond was taking medicinal marijuana but that *"he was not keen to consider reduction of his medicinal marijuana, which may actually be further exacerbating his agitation and worsening symptoms*". He was booked to see Mr. Desmond in a follow up appointment approximately a month later but failed to attend that appointment.

A review of the records of Dr. Murgatroyd, who followed Mr. Desmond from the summer of 2015 until the spring of 2016 demonstrates a number of themes and issues with respect to Mr. Desmond. Throughout this period of time, Mr. Desmond also periodically moved back and forth from New Brunswick to Nova Scotia where his wife, Shanna Borden was completing her nursing degree at St. F.X. University in Antigonish.

Over the months, some of the issues discussed included Mr. Desmond's alcohol and marijuana use, ongoing symptoms of PTSD, irritability and anger, continuing conflicts with his wife and periodic homicidal or suicidal ideation.

Over this period of time, Mr. Desmond was successful in reducing his alcohol use. In anticipation of his admission to St. Anne's Hospital, a prospect that Mr. Desmond eventually embraced, he curtailed his marijuana use as a requirement for admission there was that he be free of marijuana for at least four weeks.

Much of the documentation, both from in person meetings as well as phone calls, focuses on Mr. Desmond's increasing sense of distress concerning the motivations of his wife, and an increasingly pervasive sense of paranoia. For example, as early as July 3, 2015(P-000244, pg. 79), Dr. Murgatroyd notes "*Intrusive thoughts, disturbed sleep (including night sweats), paranoia and homicidal thoughts (without intent) all occurring on a daily basis.*"

Notes indicated that Mr. Desmond became increasingly concerned about his financial situation and his wife's role in it. In a phone contact, dated October 30, 2015(P-000244, pg.70), Dr. Murgatroyd notes "*Mr. Desmond contacted writer and stated he had been admitted to the DECH (psychiatry unit) this past Friday evening. He said he was released the following day. He indicated that the police came to get him at his house in Oromocto late Friday after they got a telephone call from Mr. Desmond's wife, who was concerned about his well being. She and Mr. Desmond had been talking on the phone earlier that night. He said that he had been working on his will at the time. Frustrated with his current situation (with his wife and her parents) he told her he was planning to leave everything to his daughter. Mr. Desmond said that his wife did not understand why he would not leave her anything. She was also worried about the fact that he was working on his will. According to Mr. Desmond, he ended the telephone call by saying "good night, goodbye" which he thinks may have worried his wife and led her to calling the police. He insisted that he did not verbalize suicidal ideation/intent to her over the phone. Shortly after, the police arrived. He said they also seized a gun he had with him.*".

During that same session, Mr. Desmond "*said he now realizes he may need more intensive programs, such as the one offered at the St. Anne's Hospital. ... Mr. Desmond also stated that the medication and medicinal marijuana may not have been effective.*".

Over the next number of months, many of the contacts with Mr. Desmond appeared to be focused on issues related to facilitating his admission to St. Anne's, which was delayed on several occasions.

There appeared to be a deterioration in April of 2016. In a meeting on April 15(p-000244, pg. 53), Dr. Murgatroyd notes "*He said he had been having nightmares lately where he catches his partner cheating on him. He states that some of the details are gruesome, for example, finding the man's head on the floor. He is wondering if there is meaning behind the dreams and whether his wife might be cheating on him. He said his wife laughed at him when he asked her about it rather than giving him a straight answer.*"

In a meeting on the 25th of that month (P-000244, pg.52), Dr. Murgatroyd writes "*He indicated that since his partner's parents have returned to Antigonish things have deteriorated in the household. According to him, his partner has been sharing sensitive/personal information about Mr. Desmond to her mom. This really upset Mr. Desmond and he feels he cannot trust his partner. He also indicates that she has been "holding on" to divorce papers, which is also*

upsetting him. He feels that she is being manipulative and is unwilling to work on the relationship."

In a joint meeting with Dr. Njoku on May 9, 2016(P-000244, pg.50), Dr. Murgatroyd notes "*Mr. Desmond was very agitated today. He was very angry with his current situation, particularly regarding his wife and their financial situation. His anger was noticeable during the session and both the writer and Dr. Njoku tried to bring him down. At times it was difficult to redirect him as he kept circling back to his situation and how his wife could not be trusted as she is ruining him financially.*". The note also indicates that Dr. Njoku was able to convince Mr. Desmond to start a new medication, Abilify (aripiprazole- an antipsychotic used in low dose as an adjunct to an antidepressant) 2 mg in the morning *"to help with his anxiety and distress".*

Mr. Desmond was admitted to the *"Stabilization Program in the Residential Treatment Clinic for Operational Stress Injuries"* (RTCOSI) at St. Anne's Hospital on Monday, July 4, 2016, and discharged from that program on August 15, 2016.

The Discharge Summary from that admission (P-000244, pgs. 85-91) would suggest, in my opinion, that Mr. Desmond made some limited strides forward. His psychologist, Dr. Isabel Gagnon, noted *"Following work on emotional regulation the client seemed able to verbalize perceptions and emotions relative to anger which, in several instances, led to observable emotional regulation in the course of sessions. However, autonomous self regulation still remained a challenge and the coping card produced in session seemed to have limited effectiveness. In periods of emotional dysregulation, Mr. Desmond was encouraged to continue to take part in treatment in valued actions and self care behaviors and the usefulness of this habit seemed to be partly integrated. However, while Mr. Desmond was able to recognize a pattern of damaging interpersonal behaviors, as the end of treatment neared, the client seemed to express growing doubts about the intentions of the treatment team, which led to increased distrust and isolation".*

His occupational therapist suggested *a "neuropsychological evaluation in order to determine M Desmond's cognitive capacities".* Why such a neuropsychological assessment could not have been done during the hospitalization is not addressed.

Mr. Desmond's social worker noted that although "*Mr. Desmond has many strengths and resources upon which he is able to go on in order to achieve his goals*" he "*struggles with interpersonal conflict usually resulting from his perception that an individual is not behaving in the way that he feels is acceptable. In these situations, his tendency is to become agitated and angry and then to avoid the situation by walking away and avoiding as much as possible any further contact with the individual.*" The social worker notes that in interactions with Mr. Desmond, although *"Mr. Desmond was able to eventually return to a calm state, he appeared to have tremendous difficulty integrating the strategies suggested and accepting responsibility for controlling his own reactions*".

At time of discharge, there were only minimal changes in Mr. Desmond's medication regime. He was discharged on Seroquel XR (an antipsychotic given in low dose as an anxiolytic) 50 mg

once a day and 25 mg three times a day as necessary and Sublinox, a hypnotic medication, as his only psychotropics.

The course of care that Mr. Desmond received following his return from St. Anne's has been the focus of considerable energy on the part of the Inquiry. Dr. Murgatroyd, in a teleconference dated August 9, 2016(P-000244, pg. 45), notes that team members from St. Anne's met with him in a teleconference in which Dr. Murgatroyd notes "*Mr. Desmond decided to leave his residential program early because he wanted to see his daughter before she started school. The team members briefly went over the recommendations, which included the need for a neuropsychological assessment to assist in determining his future treatment plan. They said they would fax the report to the writer in the coming days. Finally, the team expressed a few of the short term concerns which included his traveling plans back to New Brunswick and his living arrangements.*"

Dr. Murgatroyd was in contact by phone with Mr. Desmond again on the 24th of August (P-000244, pg.43), at which time he reported that he was residing at his in-laws residence (a family that he had had conflict with although by this time they were residing in Western Canada). Dr. Murgatroyd notes "*Once again it seems like the priority for Mr. Desmond is trying to work out things with his family. He is interested in having his file transferred to Nova Scotia.*"

In his last note, dated October 18, 2016(P-000244, pg. 42), Dr. Murgatroyd indicates that he contacted the OSI Clinic in Halifax to follow up on a referral that had been sent concerning Mr. Desmond. He notes "*The writer spoke with OSI Nurse Natasha who confirmed she contacted Mr. Desmond to complete a triage. She indicated that at this time, Mr. Desmond has a therapist in the community and that he would also be connected for psychiatric services in the community.*"

In a brief phone call with Mr. Desmond later that same day "*Mr. Desmond confirmed that the OSIC in Halifax contacted him and that at this time he would prefer accessing community resources than have to travel to Halifax. He does not yet have a local therapist but this will be discussed with his CM once she gets back from her vacation. He will also be looking at getting connected to see psychiatry in Antigonish, Nova Scotia.*"

Mr. Desmond was seen by psychiatry in Nova Scotia on a referral from a physician at the Guysborough Memorial Hospital on December 2, 2016, some months after his discharge from St. Anne's Hospital. In his consultation note (P-000071), Dr. Slater writes "*His symptoms of PTSD have included flashbacks to combat and body retrieval, nightmares relating to the same events, constant anxiety and feeling on "high alert", depression, difficulty coping with noise, avoidance of exposure to reminders of combat such as military "action movies" and video games. He tried to cope for awhile in the military by drinking and later taking prescribed marijuana. He found that marijuana made him feel worse. He began to experience frequent nightmares of his wife cheating on him. He related the nightmares to the marijuana prescribed for the PTSD. During the day, when around his wife, particularly after nightmares of her cheating on him, he becomes angry with her and believes that she might be cheating on him. At other times he is able to detach from these thoughts and realizes that she has not cheated on him.*"

Dr. Slater provided a diagnosis of major depression, posttraumatic stress disorder, *"posttraumatic brain disorder"*, *"borderline delusions re wife"*, *"r/o attention deficit disorder, suicide risk/low"*. Dr. Slater noted that *"He would benefit from and deserves an intensive treatment and rehabilitation program."* He suggested that Mr. Desmond contact the OSI Clinic in Halifax. Dr. Slater indicated that he felt that a neuropsychological assessment would be helpful and that he *"needs intensive psychotherapy for the PTSD and jealousy regarding his wife"*. Dr. Slater made some small changes to his medication regime, increasing his Trazodone and Prazosin. Dr. Slater ends with *"I would normally see someone with PTSD once, only to confirm the diagnosis and make recommendations. However, given the complexity of this case and given that he seems to be falling through the cracks in terms of follow up by military veteran programs, I said I would follow him for a short while to help him get connected."*

As noted above, after Mr. Desmond was released from St. Anne's Hospital, he returned to the Antigonish area where he was residing with his wife and daughter Aaliyah in his in-law's home while they were residing out west.

In her affidavit, Ms. Thelma Borden indicates that *"Lionel and Shanna got along well before he was sick. Lionel was sent to Afghanistan when Aaliyah was about two months old and when he came back from Afghanistan, he wasn't the same."* She further notes *"Shanna told me about an incident on New Year's Eve 2016 that she and Lionel had been at my sister Liz's camp and Shanna, Lionel, Aaliyah and Brenda were driving in Shanna's truck with Lionel behind the wheel going back to my home and because of the icy roads the truck slid off into a ditch. Lionel got very upset and blamed the incident on Shanna. Shanna told me Lionel wouldn't let the truck incident go, he had trouble letting things go since he came back from Afghanistan, he went on about the incident for days. Shanna told me she told Lionel he had to leave – Lionel said "I'm not leaving, no place, you're not taking my daughter. You can call the cops, I'm not leaving. I'll have something for them (the cops when they come). Lionel was up in her face and she had to leave the home with Aaliyah and go for a drive. After that, Lionel texted Shanna accusing her of being with somebody."*

Mr. Desmond presented at the emergency department at St. Martha's Regional Hospital on January 1, 2017(P-000067, pg. 33), just prior to 7 p.m. The note from the attending physician notes *"Issues at home, (?) with wife. Nine year old child. Outburst tonight, breaking furniture, no harm to family. Patient's wife told him "Don't come back until tomorrow."*

Mr. Desmond was admitted for *"observation"* (P-000108) under Dr. Rahman. Dr. Rahman noted that *"Patient is a 33 year old retired veteran from army, having served in Afghanistan for seven months in 2007 and suffering from PTSD"*.

Dr. Rahman notes *"Stated that argument between him and his wife started last night when their vehicle went into a ditch. Both continued to escalate until he punched/hit a table, at which point she threatened him about calling RCMP and he left the home voluntarily. ... Complains of symptoms suggestive of PTSD. Continues to experience flashbacks, nightmares. Sleep is disturbed, frustration tolerance remains low as he feels that he doesn't get any affection from his wife, who is dismissive of him. He denies abusing her physically."* According to Dr. Rahman's

note, he was requesting a stay in the hospital overnight to *"reflect and regroup. He has appts with his therapist (through VA) tomorrow. He denies any suicidal or homicidal ideation."*

He was discharged the following morning with Dr. Rahman noting (P-000108) *"Patient feeling better. Requesting discharge. Will discharge to home. Does not meet criteria for involuntary hospitalization. (no)SI (no) HI."*

Mr. Desmond's last contact with a therapist was with Ms. Catherine Chambers, M.Ed. in Counseling on January 3, 2017. In her note (P-000076, pgs.1-5), Ms. Chambers *indicates "Mr. Desmond reported that on January 1, 2017 his wife, Shanna asked for a divorce. Mr. Desmond reported feeling anxious and stressed about this and reported an increase in his PTSD symptoms as a result. Mr. Desmond reported that he decided to stay with his aunt until he could find his own apartment and his wife and daughter were staying at the family home. Mr. Desmond agreed that he would return to hospital if he felt overwhelmed or unable to cope. A safety plan and contract to this effect was agreed upon verbally during a phone call on January 3, 2017. A follow up phone call placed to Marie Doucet, VAC Case Worker on January 3, 2017 to inform her of such.".* Ms. Chambers described Mr. Desmond's affect as *"flat and his demeanor was meek and child-like. He was very polite and soft spoken. His speech was often confusing, fragmented and disorganized. It appeared to be difficult for Mr. Desmond to think and express himself clearly or in a linear fashion."*

As noted above, Mr. Desmond was seen later that day purchasing a firearm in Antigonish. Mr. Desmond, his wife Shanna, Mr. Desmond's mother Brenda and his daughter Aaliyah all died at approximately 6 p.m. that evening. Hours before, Ms. Nicole Mann, of the Naomi Society in Antigonish, received a call (Desmond Timeline) from an individual identifying herself as Lionel Desmond's ex-spouse requesting information on how to obtain a peace bond.

Discussion

Clearly, Mr. Lionel Desmond was a complicated person and his was a complicated case. Mr. Desmond's case was complicated diagnostically, clinically, and socially. It was complicated with respect to services received and the timing of those services. It was complicated with respect to interaction between different service providers from the military, private and public mental health sector and it was complicated with respect to other factors, such as Mr. Desmond's acquisition of a firearm.

Clinical Issues

Mr. Desmond's initial diagnosis was that of posttraumatic stress disorder and major depressive disorder. Readers of this report will, I am sure, be familiar with the diagnosis of posttraumatic

stress disorder and it will be reviewed briefly here. The diagnosis of posttraumatic stress disorder in the DSM 5[2] is defined as follows:

A. Exposure to actual or threatened death, serious injury or sexual violence in one (or more) of the following ways:

1. Directly witnessing the traumatic event(s);
2. Witnessing in person the event(s) as it occurred to others;
3. Learning that the traumatic event(s) occurred to a close family member or close friend;
4. Experiencing repeated or extreme exposure to adverse details of the traumatic event(s):

B. The presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s) beginning after the traumatic event(s) occurred:

1. Recurrent involuntary intrusive distressing memories of the traumatic event(s);
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s);
3. Dissociative reactions;
4. Intensive prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s);
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s):

C. Persistent avoidance of stimuli associated with the traumatic event(s) beginning after the traumatic event(s) occurred as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s);
2. Avoidance or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s):

D. Negative alterations in cognition and mood associated with the traumatic event(s) beginning or worsening after the traumatic event(s) occurred as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s);
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world;
3. Persistent disordered cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others;
4. Persistent negative emotional state;
5. Markedly diminished interest or participation in significant activities;
6. Feelings of detachment or estrangement from others;
7. Persistent inability to experience positive emotions.

[2] Diagnostic and Statistical Manual of Mental Disorders, 5th ed. American Psychiatric Press, 2013.

E. Marked alterations in arousal and reactivity associated with the traumatic event(s) beginning or worsening after the traumatic events occurred as evidenced by two or more of the following:

1. Irritable behavior and angry outbursts typically expressed as verbal or physical aggression towards people or objects;
2. Reckless or self destructive behavior;
3. Hypervigilance;
4. Exaggerated startle response;
5. Problems with concentration;
6. Sleep disturbances.

Note has been made that PTSD has a dissociative subtype with the DSM 5 noting:

"The individual's symptoms meet the criteria for posttraumatic stress disorder and in addition, in response to the stressor, an individual experiences persistent or recurrent symptoms of either of the following:

1. Depersonalization: persistent or recurrent experiences of feeling detached from and as if one were an outside observer of one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality in self or body or of time moving slowly);

2. Derealization: persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant or distorted.".

In brief, PTSD involves several symptom clusters; more specifically, clusters related to intrusive symptoms, avoidant symptoms, changes in cognition and mood, and features of hyperarousal.

Not all individuals who are exposed to trauma develop PTSD; in fact, a minority do[3]. The likelihood of developing psychopathology following trauma, including PTSD, involves a number of risk factors which can be grouped into pre-traumatic, peri-traumatic, and post-traumatic domains[4].

Pre-traumatic risk factors include age, education/IQ, race and ethnicity, sexual orientation, pre-trauma psychopathology, trauma exposure, and familial psychiatric history. It should be noted that not all the findings in this area are conclusive, but some, such as cognitive reserve, and prior exposure to trauma, are. In Mr. Desmond's case, there is no clear history of pre-trauma psychopathology but there do remain some unanswered questions about previous trauma exposure in his early years and, as he was raised in a single parent family, his familial psychiatric history.

Peri-traumatic factors include the trauma, type, and severity; without question, Mr. Desmond's exposure would be a significant risk factor.

Early intervention is critical in the treatment of any psychiatric disorder, and this is true for posttraumatic stress disorder. The *Sayed et al* review notes *"several psychosocial factors are*

[3] Handbook of PTSD; Science and Practice, 2nd Ed. Guilford Press, 2014.
[4] Sayed.S et al. Risk Factors for the Development of Psychopathology Following Trauma. Current Psychiatry Rep (2015) 17:70

associated with resilience following trauma to decrease the chance of developing psychopathology such as depression, substance abuse and PTSD. These factors include optimism, cognitive flexibility, active coping skills, the extent of one's social support network, physical health and embracing a moral compass".

Unfortunately, from my review of material, Mr. Desmond was not provided with early intervention. As noted above, the first record that I have of consultation with psychiatric services concerning his PTSD dates to 2011, some years after his deployment. Further, as noted above, Mr. Desmond's social network was fragmented. This was in part due to his separation from his unit, a key support structure and would also include his separation from his wife and members of his family in Nova Scotia when Mr. Desmond was residing in New Brunswick and his wife was pursuing her education in nursing in Nova Scotia. Early identification of Mr. Desmond's posttraumatic stress disorder, early intervention, and concerted efforts to enhance and support his social network may have been helpful in mitigating some of the chronic symptomatology that he eventually developed.

Through the course of his care, Mr. Desmond received services from a number of care providers while as a member of the armed services, as a veteran, and later in the public or civil mental health system. He appears, from my review of material, to have had the most in-depth psychotherapy from Dr. Rogers while still an active service member and had a positive relationship with Dr. Murgatroyd.

Unfortunately, transitions were difficult for Mr. Desmond, and he was not able to keep the same clinicians as he transitioned from active status to veteran status. In psychotherapy, consistency over time with a therapist with whom one has a good match can be critical to success.

Although Mr. Desmond's primary diagnosis was that of PTSD, several other diagnoses were raised. The other diagnosis that follows Mr. Desmond throughout time consistently is that of major depressive disorder. Comorbidity is highly prevalent in PTSD with major depression being the most comorbid condition[5]. However, there is also the possibility that the two diagnoses could be conflated as, as noted above, changes in cognition and mood are a feature of PTSD itself.

Although the primary treatment for posttraumatic stress disorder is psychotherapeutic in nature, psychopharmacological agents, particularly antidepressants, are often used in cases of PTSD to deal with the emotional symptoms and would concurrently be the treatment of choice for major depressive disorder[6]. Mr. Desmond's primary antidepressant treatment appears to have been Venlafaxine (Effexor) as started by Dr. Joshi; more aggressive approaches psychopharmacologically to Mr. Desmond's depressed mood may have been warranted, although records would seem to suggest that his mood was variable, often reactive to external stressors, and that Mr. Desmond appeared to be sensitive to side effects.

Other diagnostic issues raised over the course of Mr. Desmond's treatment include Dr. Slater's diagnosis of *"posttraumatic brain disorder"*, his comments about *"borderline delusions"*

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[5] Handbook of PTSD. Ch. 20: Assessment of PTSD and its Comorbidities.

[6] Gorman, N. A Guide to Treatments that Work. Oxford University Press, 2015.

concerning Shanna Desmond as held by Mr. Desmond and the materials from St. Anne's, that speak to "*mixed personality traits*" (P-000254, and testimony of Dr. Robert Ouellette).

The matter of the "*posttraumatic brain disorder*" cannot be easily rectified. Materials indicate that Mr. Desmond had several concussions, although the exact details of these are unknown. Unfortunately, Mr. Desmond did not have formal neuropsychological testing to quantify any cognitive strengths or weaknesses. Further, as impairment in concentration is a symptom of both depression and PTSD, Mr. Desmond's cognitive complaints could have been a symptom of a pre-existing mental disorder. Early neuropsychological testing after return from deployment, especially in an individual with known head injuries may have helped separate neurocognitive issues from concentration issues secondary to PTSD or depression.

A comment about paranoid personality traits and borderline personality disorder is warranted. Personality disorders involve, as per the DSM 5 *"an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the person's culture"*. A personality disorder is a longitudinal diagnosis in which the early precursors can often be observed in childhood and adolescence.

Dr. Ouellette felt that Mr. Desmond had paranoid personality traits, but not paranoid personality disorders. This is supported in my opinion, in that there is no material available to me to suggest that Mr. Desmond was suspicious or mistrustful in his youth, although, clearly, mistrust of others, including peers, care providers, and in particular, his wife, became prominent later on after his diagnosis of PTSD; this leads directly to Dr. Slayter' s concern about *"borderline delusions"*.

The information available to me would indicate that over time Mr. Desmond became increasingly preoccupied with concerns about the potential infidelity of his wife and increasingly concerned that she could not be trusted and indeed was taking advantage of him. In my opinion, it could not be said that these were held with delusional intensity. Although Mr. Desmond at times appeared to be greatly distressed by these ideas, they do not have the hallmark of delusion in that they were not held with 100 percent certainty by Mr. Desmond. Even if they had been held with delusional intensity, that would not have, in my opinion, created a scenario in which, had he survived, the actions of Mr. Desmond could have, for example, led to a successful defense of not criminally responsible. As per Section 16.1 of the Criminal Code of Canada, such a delusion would only lead to a successful defense if as a result of the delusion Mr. Desmond was unable to appreciate the nature and quality of his actions or unable to appreciate their wrongfulness. In my experience, for individuals with paranoid delusions, this usually arises in the context where the perpetrator believes, on a delusional basis that their life is in immediate danger and responds in kind.

Borderline personality disorder is a personality disorder in which a key symptom is emotional lability or dysregulated affect, including rapid changes in mood and difficulties with anger. In this regard, it is very similar to the hyperarousal symptoms seen in posttraumatic stress disorder and presents yet another confound diagnostically. However, in my opinion, there is very little to suggest that Mr. Desmond had features of borderline personality prior to his deployment. Recall that as a personality disorder, one would normally expect to see features of the personality

disorder prior to the age of 18, when it can be formally diagnosed. File review and collateral information would suggest that Mr. Desmond did not have the mood lability of that disorder during his early formative years.

Throughout Mr. Desmond's care, mention is made of flashbacks and other dissociative episodes. Flashbacks are dissociative events in which the individual, to use the vernacular, is "lost in the moment", that moment being a moment from the past. In the DSM 5, the dissociative subtype of PTSD is characterized by issues with derealization or depersonalization, in which there is not a loss of reality testing but rather a sense of separateness from one's reality.

There is evidence by review of files (see affidavit of Ms. Theresa Borden) that on at least one occasion Mr. Desmond choked his wife in what appears to have been a reaction to awakening from a nightmare or a flashback.

It is unlikely, in my opinion, that such an event is causally related to the tragic events of January 3, 2017. An early report on flashbacks from 1985 notes[7] "*Data from structured interviews indicate that certain affects, loud noises, fatigue and personal stress tend to precipitate flashback episodes. Data also indicate that flashbacks were not generally associated with an overt aggressive act, although aggressive or defensive posturing occurred, and flight was common*".

A more recent paper looking at the association of violence and dissociation more generally[8] noted in conclusion that "*recent criminal justice involvement among our DD* (dissociative disorder*) criminal sample is low, according to patient self reports and is not predicted by dissociative, PTSD or emotion dysregulation symptoms, nor by clinician reported substance abuse disorders or mood disorders. This provides compelling evidence contradicting public and media misconceptions and stereotypes of those with DDs as highly prone to criminality and violence.*"

The extended time course of Mr. Desmond's actions on January 3, 2017, and his ability to interact with others over that time, in my view, are not consistent with a dissociative episode involving flashbacks.

A final clinical matter to deal with, with respect to Mr. Desmond, before turning to other issues, is his use of alcohol and cannabis and their potential impact on his behavior.

With respect to alcohol, records show that Mr. Desmond at times would utilize alcohol, perhaps as a coping mechanism to help deal with his PTSD. At times his alcohol consumption would become problematic and indeed Mr. Desmond was seen by an addictions counselor for this. However, information also demonstrates that Mr. Desmond was able to decrease his alcohol intake and there is nothing in the file information available to me to suggest that alcohol was involved in any disruptive behavior on the part of Mr. Desmond.

With respect to cannabis, Mr. Desmond was prescribed medicinal cannabis which was managed by Dr. Smith. Dr. Smith testified before the inquiry and spoke at some length about his views of

[7] Mellman, T.A. Combat related flashbacks in PTSD. Journal of Clinical Psychiatry, 46(9), 379-382.
[8] Webermann A., Brand, B. Mental Illness and violent behavior: the role of dissociation.

medicinal cannabis and the role of various preparations. Whether Mr. Desmond himself found benefit from cannabis is, from review of records, equivocal. At times he reported that the cannabis helped relax him but ultimately, he discontinued cannabis. This was not only as part of the requirements prior to his going to St. Anne's Hospital, but because he reported that he found it inefficacious.

Literature on the use of cannabis and cannabis products in mental health is emerging. There is clear evidence now that heavy cannabis use, particularly at an early age, is a significant risk factor for the onset of psychotic disorders, such as schizophrenia[9], although there is no evidence that Mr. Desmond had a psychotic disorder. Moreover, although cannabis is widely used for other psychiatric conditions and for pain, at least with respect to the form, caution is warranted. A recent review notes[10] "*The present evidence in the emerging field of cannabinoid therapeutics in psychiatry is nascent, and thereby it is currently premature to recommend cannabinoid-based interventions. Isolated positive studies have, however, revealed tentative support for cannabinoids (namely cannabidiol, CBD) for reducing social anxiety; with mixed (mainly positive) evidence of adjunctive use in schizophrenia. Case studies suggest that medicinal cannabis may be beneficial for improving sleep in posttraumatic stress disorder, however, evidence is currently weak.*".

I have no information to suggest that cannabis use was prevalent for Mr. Desmond in the period of time leading up to and including the events of January 3, 2017.

Suicide/Suicide Risk Assessment

Given Mr. Desmond's chronic suicidal ideation as reported to others, a review of suicide and the related issue of suicide risk assessment is warranted.

Suicide is a major public health problem worldwide[11]. The overall suicide rate varies from year to year in Canada but in general, hovers around 12 per hundred thousand population; it was 10.82/100.000 in 2019, early 2020 and actually fell during the current pandemic[12]. Suicide rates are disproportional by gender; men commit suicide roughly three times as often as women, although women attempt suicide more often than men. Men over the age of 75 have the highest suicide rate.

There are a number of other population groups that have higher than average suicide rates. These include individuals with disabilities, chronic pain, first nation individuals in Canada and

[9] Colizzi, M. Murray, R. Cannabis and Psychosis: what do we know and what should we do? BJP2018
[10] Sarris, J. et al. Medicinal cannabis for psychiatric disorders; a clinically focused systematic review. BMC Psychiatry (2020) 20:24.
[11] Preventing Suicide: a global imperative. World Health Organization 2014.
[12] McIntyre, R. Suicide Reduction in Canada during the COVID -19 pandemic. J of the Royal Society of Medicine 2021

LGBTQ individuals. Of particular note, service members and veterans have higher than average population rates of suicide[13].

An important aspect of managing this public health issue is the identification and management of suicide risk. The prediction of suicide, however, runs into the problem of the so-called "base rate problem". Given that suicide is, statistically speaking, a low probability event, any test attempting to assess suicide will, by its nature, have a high false positive rate, as the absolute risk of suicide is low[14]. Hence, although there are a number of suicide risk assessment instruments available and assessment of suicide risk is an expected standard of care under Accreditation Canada, reliably predicting suicide is difficult.

An approach to suicide risk assessment can be tailored, much as the literature in violent risk assessment, by looking at static and dynamic risk factors. A static risk factor is a risk factor that is unchangeable but predicts the outcome of interest, and in the case of suicide includes previous history of suicide attempts, gender, and previous history of trauma. Dynamic risk factors are those which are modifiable and include such factors as substance use and social stability. It needs to be understood, however, that some of these dynamic risk factors can change quickly and in an unpredictable fashion.

It is best, perhaps, to think of a suicide risk assessment as a touch point both to establish rapport with the client and to help develop a suicide prevention strategy. Identification of key risk factors, particularly dynamic risk factors, would be of assistance in developing an ongoing treatment plan. Note is made that Ms. Chambers, in her last contact with Mr. Desmond, developed a *"safety plan and contract"* with him with respect to returning to hospital if he felt overwhelmed.

Unfortunately, such agreements have limited utility. There are, however, potential preventative strategies that may be helpful. To that end, the authors of a text on "*Veteran psychiatry in the* US"[15] note *"Stanley and Brown developed a safety plan intervention (SPI), a brief stand alone intervention that involves the collaboration of the written list of resources and coping strategies that a patient can utilize in the event of a suicidal crisis. Specifically, this list enumerates the steps that should be taken during and leading up to a suicide health crisis. These include recognizing warning signs, using predetermined coping strategies, contacting social support for distraction and crisis resolution, and reaching out to professionals and EDs. The SPI additionally includes a discussion of lethal means reduction. Safety planning of this kind is premised on the notion that it is more effective to establish positive crisis management strategies (with concrete steps) than it is to solicit an agreement to keep "safe" and not engage in any suicidal behavior."*

Readers will note that throughout Mr. Desmond's course of care, he was periodically evaluated for suicide risk, which was generally felt to be low. However, given the persistence of his

[13] Nelson, H.et al. Suicide Risk Assessment and Prevention: A systematic Review Focusing on Veterans. Psych Services 68:10, Oct. 2017.
[14] Gold. L., Frierson, R, editors. Textbook of Suicide Risk Assessment and Management. American Psychiatric Press 2020.
[15] Ritchie, E.C, Llorente, M, ed. Veteran Psychiatry in the US. Springer, 2019

suicidal ideation, such a program may have been of benefit to him and certainly the persistence of his suicidal ideation over time would suggest close monitoring was necessary, particularly in potential situations where there were changes in the dynamic variables associated with Mr. Desmond.

Violence Related Issues

Given that Mr. Desmond had a psychiatric disorder, and given that the events of January 3, 2017, involved violence not only towards Mr. Desmond but towards others, a more general review of violence in psychiatric disorders, with a particular attention to individuals in the military, is warranted.

The same issues noted above with respect to suicide related to its relatively low base rate and the difficulties in prediction as a result, are true in the prediction of violence risk. Similar to suicide, violence risk prediction can be thought of as utilizing both static and dynamic risk factors. In general, there are a number of approaches to violent risk assessment. In the oldest, the clinical approach, and individual's risk for violence is assessed based on his or her clinical experience and usually defined in dichotomous terms as either high or low. The accuracy of such assessments is generally no better than chance alone.

Actuarial approaches (such as the VRAG[16], commonly used in forensic settings) utilize known static risk factors associated with violence risk in individuals who already have a violent history as determined by adjudication by the courts. Static risk factors for violence include prior criminal history, substance use history, and personality disorder. Actuarial approaches produce probability scores predicting the probability of violent recidivism over a fixed period of time.

Another approach in use now is the structured clinical judgement approach. In this approach, known risk factors associated with violence risk are combined and an overall global assessment of risk, usually rated as low, medium, or high, is given. These risk assessments usually combine a number of historical factors (such as past violence, criminal history, presence of psychiatric illness), clinical risk factors (such as adherence to treatment, active substance use) and risk management items.

There is a lingering stigma in the public imagination that individuals with mental disorders are violent, a notion promulgated by sensationalistic media reporting or other media, such as movies, that utilize this meme.

Although in general, individuals with mental health disorders are more likely to be victims of crime than perpetrators of crime, there are some categories where the presence of a mental disorder increases the risk of violence. A recent publication in The Lancet Psychiatry[17] notes *"Absolute rates of violent crime over 5-10 years are typically below 5 percent in people with mental illness (excluding personality disorder, schizophrenia and substance misuse) which*

[16] Harris, G. et al. Violent Offenders: appraising and managing Risk; 3rd ed. American Psychological Association Press,2015

[17] Whiting, D. et al. Violence and Mental Disorders: a structured review of associations by individual diagnosis, risk factors, and risk assessment. Lancet Psychiatry, Oct. 20, 2020.

increases to 6-10 percent in personality disorders and schizophrenia disorders and to more than 10 percent in substance misuse. Past criminality and comorbid substance misuse are strongly predictive of future violence in many individual disorders.".

In a publication in The Lancet from 2013, focused on veterans[18], the authors noted that *"in UK military personnel who had been deployed to the middle east, violent offending was associated with post deployment alcohol misuse, posttraumatic stress disorder, and high levels of self reported aggressive behavior."*. Interestingly, they note "*Of the posttraumatic stress disorder symptoms, the hyperarousal cluster was most strongly associated with violent offending*".

In applying all of this to Mr. Desmond, it can be seen that significant risk factors for violence included his diagnosis of PTSD, with particular awareness given to the fact that Mr. Desmond appeared to have a large number of hyperarousal symptoms (including anger, as discussed above). Risk factors related to interpersonal violence are beyond the scope of my review, but I would suggest that Mr. Desmond's ongoing conflictual relationship with his wife could readily be seen as a risk factor for future violence.

Issues of Homicide-Suicide

Many of the issues discussed above relating to the difficulties of predicting suicide and violence are applicable, but even more so, to the issue of homicide-suicide. Homicide-suicide can be defined as *"an act of murder of one or several individuals that is followed not long after by the suicide of the perpetrator"*[19]. Although clearly a tragedy for all concerned, absolute rates of homicide-suicide are low, ranging, for example, in the United States between .134 to .55 per hundred thousand per year (contrasted to the rate of around 12 per hundred thousand per year for suicide noted above).

Various typologies of homicide-suicide have been proposed. Most of these have been based on an attempt to characterize the relationship between the victim and the perpetrator and the motive of the perpetrator although, with respect to this point of course, motive can only be inferred as the perpetrator is himself or herself deceased.

The most common pattern, accounting for approximately 50 to 75 percent of all homicide-suicides is known as the intimate possessive. As noted in the Psychiatric Clinics of North America, this "*involves a male in his 30s or 40s recently estranged from his partner. Relationship often characterized by domestic abuse and multiple separations and reunions.*".

Other categories include intimate physically ailing, extrafamilial homicide-suicide (for example disgruntled employees), filicide-suicide (most commonly the killing of children by a parent) and of particular interest in this matter, familicide-suicide. This latter category "*involves the depressed senior man of the household. There are often associated precipitating stressors and marital problems, finances, or work-related problems. He may view his action as an altruistic "delivery" of his family from continued hardships. He may also suspect marital infidelity and be*

[18] MacManus, d. et al. Violent Offending by UK military personnel deployed in Iraq and Afghanistan. The Lancet. Mar 16, 2013.
[19] Knoll, JL. Understanding Homicide-Suicide. Psychiatr. Clin N Am 39 (2016) 633-647.

misusing substances. There is usually evidence of depression or depressive cognitions distorting judgement."

A recent study in the US[20] showed that the vast majority of homicide-suicide deaths were caused by firearms with the authors concluding "*The overwhelming majority of homicide-suicide deaths involve firearms which supports the need for adequate appropriate firearm control measures to prevent these tragedies*".

Conclusion

Mr. Lionel Desmond was a 33-year-old male, a veteran of the Canadian Armed Forces, who had posttraumatic stress disorder developing following his deployment to Afghanistan. Symptoms of PTSD interacted with and were exacerbated by concurrent social problems involving a number of issues, including difficulties in his work environment, difficulties transitioning to a civilian role, conflict with his wife and a lack of easily accessible community support., which, in a circular fashion, caused further exacerbation of these issues. Transitions between care providers and systems were problematic.

In the course of this review, I have commented on a number of clinical matters, encompassing clinical and diagnostic issues, suicide and suicide assessment, violence in mental disorders, and the issue of homicide-suicide. Taking all of this information into account, viewed through the perspective of a psychological autopsy and without wishing to usurp in any way the role of the Inquiry, clinically, the actions of Mr. Desmond on the 3rd of January 2017 best fits the profile for a case of homicide-suicide of the familicide-suicide type. My comments are not in any way meant to interfere with the jurisdiction of the Inquiry but are meant merely to provide the Inquiry with hopefully a better understanding of the complex life and history of Mr. Lionel Desmond.

Respectfully submitted,

P.S. Theriault, MD, FRCPC

[20] Schwab-Reese, L. Factors contributing to homicide-suicide: difference between firearm and non-firearm deaths. J Behav Med (2019) 42: 681-90.

Appendix A

Desmond Fatality Inquiry

Working Desmond Timeline

Desmond Fatality Inquiry

New Brunswick OSI Timeline 1

Quebec Timeline 2

Desmond Fatality Inquiry

Domestic Violence Risk Factors – New Brunswick 1

Domestic Violence Risk Factors – Quebec 2

Canadian Armed Forces
Exhibit List

EXHIBIT #	DESCRIPTION
P-000136	Sept 22 2014 Request for Tertiary Investigation
P-000183	Medical Report
P-000184	Letter - dated October 28, 2012
P-000185	Psychiatric Assessment - September 25, 2013
P-000186	Medical Examination for Administrative purposes - October 22 2014
P-000187	Complexity Assessment Interview Questionnaire - November 18 2013
P-000188	Psychiatry Progress Report - October 5,2011
P-000189	Psychiatry Progress Report - October 27 2011
P-000190	Psychiatry Progress Report - May 3 2012
P-000191	Psychiatry Progress Report - June 6, 2012
P-000192	Psychiatry Progress Report - July 31, 2012
P-000193	Psychiatry Progress Report - October 2, 2012
P-000194	Psychiatry Progress Report - November 6, 2012
P-000195	Psychiatry Progress Report - December 13, 2012
P-000196	Psychiatry Progress Report - February 27, 2013
P-000197	Psychiatry Progress Report - March 27, 2013
P-000198	Psychiatry Progress Report - April 4, 2013
P-000199	Psychiatry Progress Report - May 7, 2013
P-000200	Psychiatry Progress Report - May 28, 2013
P-000201	Psychiatry Progress Report - June 6, 2013

Canadian Armed Forces
Exhibit List

EXHIBIT #	DESCRIPTION
P-000202	Psychiatry Progress Report - June 20, 2013
P-000203	Psychiatry Progress Report - July 18. 2013
P-000204	Psychiatry Progress Report - August 29, 2013
P-000205	Psychiatry Progress Report - October 10, 2013
P-000206	Psychiatry Progress Report - November 12, 2013
P-000207	Psychiatry Progress Report - November 19, 2013
P-000208	Psychiatry Progress Report - January 7, 2014
P-000209	Psychiatry Progress Report - February 18. 2014
P-000210	Psychiatry Progress Report - April 17, 2014
P-000211	Psychiatry Progress Report - June 19, 2014
P-000212	Psychiatry Progress Report - July 17, 2014
P-000213	Psychiatry Progress Report - September 3, 2014
P-000214	Psychiatry Progress Report - October 2, 2014
P-000215	Psychiatry Progress Report - December 2, 2014
P-000216	Psychiatry Progress Report - February 18,2015
P-000217	Psychiatry Progress Report - April 16, 2015
P-000218	Psychiatry Progress Report - June 16, 2015
P-000219	Medical Report - January 27, 2012
P-000220	Psychology Progress Report - February 9, 2012
P-000221	Psychology Progress Report - February 23, 2012

Canadian Armed Forces
Exhibit List

EXHIBIT #	DESCRIPTION
P-000222	Psychology Progress Report - February 19, 2013
P-000223	Psychology Progress Report - September 10, 2013
P-000224	Nurse Case Management - April 13, 2015
P-000225	Dependency Assessment - May 20, 2015
P-000226	Discharge Summary - June 13, 2016
P-000227	Email - Follow Up from Padre Taylor - September 16, 2013
P-000228	Psychiatry Progress Note - October 2, 2014
P-000229	Psychiatry Progress Note - February 18, 2015
P-000230	Psychiatry Progress Note -April 16, 2015
P-000232	Psychology Progress Report - Dec 1, 2011
P-000233	Psychology Progress Report - February 9, 2012
P-000234	Psychology Progress Report - April 26, 2012
P-000235	Allied Note - September 10, 2012
P-000236	Medical Report
P-000237	Psychology Progress Report - November 15, 2012
P-000238	Psychology Progress Report - November 29, 2012
P-000239	Document - February 26, 2013
P-000240	Document - September 25, 2013
P-000241	Email - September 27, 2013
P-000242	Protected B Document - May 13, 2015

Canadian Armed Forces
Exhibit List

EXHIBIT #	DESCRIPTION
P-000251	Medical Report
P-000252	Medical Report
P-000300	Nurse Case Management
P-000301	Nurse Case Management

Canadian Armed Forces
Index

Name of Witness/Title	Tab
Dr. Vinod Joshi	
Part-time Adult Consultant Psychiatrist Mental Health Services, Horizon Hospital, Saint John, NB	1
Part-time Consultant Psychiatrist Mental Health Services, Canadian Forces, NB	
Part-time Consultant Psychiatrist, Opiate Replacement Treatment Program, NB	
Exhibits Referenced:	
P-000136 – Sept 22, 2014 – Request for Tertiary Investigation	
P-000183 – Medical Report	
P-000184 – Letter – dated October 28, 2012	
P-000185 – Psychiatric Assessment – September 25, 2013	
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P-000194 – Psychiatry Progress Report – November 6, 2012	
P-000195 – Psychiatry Progress Report – December 13, 2021	
P-000196 – Psychiatry Progress Report – February 27, 2013	
P-000197 – Psychiatry Progress Report – March 27, 2013	
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P-000209 – Psychiatry Progress Report – February 18, 2014	
P-000210 – Psychiatry Progress Report – April 17, 2014	
P-000211 – Psychiatry Progress Report – June 19, 2014	
P-000212 – Psychiatry Progress Report – July 17, 2014	
P-000213 – Psychiatry Progress Report – September 3, 2014	
P-000214 – Psychiatry Progress Report – October 2, 2014	
P-000215 – Psychiatry Progress Report – December 2, 2014	

P-000216 – Psychiatry Progress Report – February 18, 2015 P-000217 – Psychiatry Progress Report – April 16, 2015 P-000218 – Psychiatry Progress Report – June 16, 2015 P-000219 – Medical Report – January 27, 2012 P-000220 – Psychology Progress Report – February 9, 2012 P-000221 – Psychology Progress Report – February 23, 2012 P-000222 – Psychology Progress Report – February 19, 2013 P-000223 – Psychology Progress Report – September 10, 2013 P-000224 – Nurse Case Management – April 13, 2015 P-000225 – Dependency Assessment – May 20, 2015 P-000226 – Discharge Summary – June 13, 2016 P-000227 – Email – Follow Up from Padre Taylor – September 16, 2013 P-000228 – Psychiatry Progress Note – October 2, 2014 P-000229 – Psychiatry Progress Note – February 18, 2015 P-000230 – Psychiatry Progress Note – April 16, 2015 P-000232 – Psychology Progress Report – Dec 1, 2011 P-000233 – Psychology Progress Report – February 9, 2012 P-000234 – Psychology Progress Report – April 26, 2012 P-000235 – Allied Note – September 10, 2021 P-000236 – Medical Report P-000237 – Psychology Progress Report – November 15, 2012 P-000238 – Psychology Progress Report – November 29, 2012	

P-000239 – Document – February 26, 2013 P-000240 – Document – September 25, 2013 P-000241- Email – September 27, 2013 P-000242 – Protected B Document – May 13, 2015 P-000251 – Medical Report P-000252 – Medical Report P-000300 – Nurse Case Management *[Canadian Armed Forces – Nurse Report – February 11, 2015]* P-000301 – Nurse Case Management *[Canadian Armed Forces – Nurse Report – April 13, 2015]*	
Dr. Wendy Laurel Rogers Clinical Psychologist, Calian, NB Contracted to work for Department of National Defence, CFB Gagetown 42 Health Services, NB **Exhibits Referenced:** P-000232 – Psychology Progress Report – December 1, 2011 P-000233 – Psychology Progress Report – February 9, 2012 P-000234 – Psychology Progress Report – April 26, 2012 P-000235 – Allied Note – September 10, 2012 P-000236 – Medical Report P-000237 – Psychology Progress Report – November 15, 2012 P-000238 – Psychology Progress Report – November 29, 2012 P-000223 – Psychology Progress Report – September 10, 2013 P-000227 – E-mail – Follow Up from Padre Taylor – September 16, 2013 P-000241 – E-mail – September 27, 2013	2

P-000242 – Protected B Document – May 13, 2015 P-000239 – Document – February 26, 2013	

Domestic Violence and Firearms Purchase Exhibit List

EXHIBIT #	DESCRIPTION
P-000078	Nicole Mann's Report re. January 3, 2017 call from Shanna Desmond
P-000079	Transcribed Statement Nicole Mann January 4, 2017
Not marked as an Exhibit	Transcribed Statement Daniel Kulanek January 4, 2017
P-000112	USB-Gun Shop Video

Statement

Domestic Violence and Firearms Purchase Index

Name of Witness/Title	Tab
Nicole Mann Executive Director Naomi Society, Antigonish, NS **Exhibits Referenced:** P-000079 – Transcribed Statement Nicole Mann January 4, 2017 P-000078 – Nicole Mann's Report re. January 3, 2017 call from Shanna Desmond	1
Daniel Kulanek Owner-Operator Leaves and Limbs Sports Lower South River, Antigonish Co., NS **Document:** Transcribed Statement Daniel Kulanek January 4, 2017 **Exhibit Referenced:** P- 000112 – USB – Gun Shop Video *[January 3, 2017 video of Lionel Desmond purchasing the firearm later used that day in the tragedy]*	2

Family and Historical Information
Exhibit List

EXHIBIT #	DESCRIPTION
P-000077	Screenshot - Text messages - December 9 and 14, 2016 and January 2, 2017
P-000162	Trans of Audio Statement-Cassandra Desmond
P-000164	Trans of Audio Statement-Kenny Greencorn
P-000165	Trans of Audio Statement-Chantel Desmond
P-000167	Trans of Audio Statement-Ricky Borden
P-000168	Affidavit of Richard (Ricky) Borden
P-000169	Trans of Audio Statement-Thelma Borden
P-000170	Affidavit of Thelma Borden
P-000171	Trans of Audio Statement-Shonda Boparai
P-000175	Text between Lionel Desmond and Shonda Boparai
P-000176	Text between Lionel Desmond and Shonda Boparai
P-000177	Text between Lionel Desmond and Shonda Boparai
P-000178	Text between Lionel Desmond and Shonda Boparai
P-000179	Text between Lionel Desmond and Shonda Boparai
P-000180	Text between Lionel Desmond and Shonda Boparai
P-000181	Text between Lionel Desmond and Shonda Boparai
P-000182	Text between Lionel Desmond and Shonda Boparai
P-000285	Dec 2, 2016 Text from Lionel Desmond to Shonda Borden

Family and Historical Information
Index

Name of Witness/Title	Tab
Shonda Borden (Boparai) – Testimony on February 19, 2021 **Relationship:** Shanna Desmond's sister Aaliyah Desmond's aunt	1
Shonda Borden (Boparai) – Testimony on June 21, 2021 **Relationship:** Shanna Desmond's sister Aaliyah Desmond's aunt **Exhibits Referenced:** P-000171 – Trans of Audio Statement of Shonda Boparai P-000175 – Text between Lionel Desmond and Shonda Boparai P-000176 – Text between Lionel Desmond and Shonda Boparai P-000177 – Text between Lionel Desmond and Shonda Boparai P-000178 – Text between Lionel Desmond and Shonda Boparai P-000179 – Text between Lionel Desmond and Shonda Boparai P-000180 – Text between Lionel Desmond and Shonda Boparai P-000181 – Text between Lionel Desmond and Shonda Boparai P-000182 – Text between Lionel Desmond and Shonda Boparai	2

Sheldon Borden **Relationship:** Shanna Desmond's brother Aaliyah Desmond's uncle	3
Richard (Ricky) Borden **Relationship:** Shanna Desmond's father Aaliyah Desmond's grandfather **Exhibits Entered:** P-000167 – Trans of Audio Statement – Ricky Borden P-000168 – Affidavit of Richard (Ricky) Borden	4
Thelma Borden **Relationship:** Shanna Desmond's mother Aaliyah Desmond's grandmother **Exhibits entered:** P-000169 – Trans of Audio Statement – Thelma Borden P-000170 – Affidavit of Thelma Borden	5
Cassandra Desmond **Relationship:** Brenda Desmond's daughter Lionel Desmond's sister Aaliyah Desmond's aunt **Document:** Trans of Audio Statement – Cassandra Desmond	6
Chantel Desmond **Relationship:** Brenda Desmond's daughter Lionel Desmond's sister Aaliyah Desmond's aunt	7

Document: Trans of Audio Statement – Chantel Desmond	
Paul Long **Relationship:** Former School Principal, Vice-Principal, Guidance Counsellor Guysborough School, Guysborough, NS	8
Albert "Junior" MacLellan Presently Employed: Connecting with Communities [an initiative by Department of National Defence to bring more visible minorities into the Canadian Armed Forces] Former employment: Warrant Officer – Canadian Armed Forces **Relationship:** Lionel Desmond's grandfather is Albert "Junior" MacLellan's great-uncle	9
Corporal Orlando Trotter **Relationship:** Member of Platoon with Lionel Desmond in Canadian Armed Forces and Friend	10
Diane Desmond **Relationship:** Brenda Desmond's daughter Lionel Desmond's sister Aaliyah Desmond's aunt	11
Kaitlyn Desmond **Relationship:** Brenda Desmond's daughter Lionel Desmond's sister Aaliyah Desmond's aunt	12

Kenny Greencorn **Relationship:** Lionel Desmond's uncle **Exhibit Referenced:** P-000164 – Trans of Audio Statement – Kenny Greencorn	13

Marie-Paule Doucette
Exhibit List

EXHIBIT #	DESCRIPTION
P-000117	Case Plan
P-000273	CAN002252 March 2021 Redactions
P-000278	Transition Interview
P-000291	Area Counsellor Assessment CSDN LD
P-000292	Client Initiated Screenings [CSDN]

P-000117
P-000273
P-000278

Marie-Paule Doucette, Veterans Affairs Canada
Index

Name of Witness/Title	Tab
Marie-Paule Doucette – Testimony of June 22, 2021 Employee Assistance Program – Short term Mental Health Counselling, NB Previously employed: Case Manager, Veterans Affairs Canada, Montreal, QC **Exhibits Referenced:** P-000117 – Case Plan *[Veterans Affairs Case Plan Entries Re: Lionel Desmond – 17 pages]* P-000278 – Transition Interview *[May 25, 2015]* P-000273 – CAN002252 – March 2021 Redactions *[Marie-Paule Doucette's Client Notes]* P-000291 – Area Counsellor Assessment CSDN LD *[Marie-Paule Doucette – January 5, 2016 – Area Report]* P-000291 – Client Initiated Screenings – CSDN *[Veterans Affairs Canada – Client Screening Records]*	1
Marie-Paule Doucette – Testimony of June 23, 2021	2

New Brunswick Community Healthcare Professional Exhibit List

EXHIBIT #	DESCRIPTION
P-000140	Desmond Medical Records Dr. Smith - 48 pages
P-000144	Posttraumatic stress disorder (PTSD); depression; suicidal dated 2013-10-29
P-000145	CFHS Chit
P-000146	Report
P-000148	Drug Use
P-000150	Medical Report

New Brunswick Community Healthcare Professional Index

Name of Witness/Title	Tab
Dr. Paul A.S. Smith – Testimony of February 24, 2020 Family Medicine/General Practice Physician, NB President of Dr Paul A S Smith Professional Corp Practice in (Harvey, McAdam and Fredericton) NB **Exhibits Referenced:** P-000140 – Desmond Medical Records Dr. Smith – 48 pages P-000148 – Drug Use P-000150 – Medical Report P-000146 – Report P-000144 – Posttraumatic stress disorder (PTSD); depression; suicidal dated 2013-10-29 P-000145 – CFHS Chit	1
Dr. Paul A.S. Smith – Testimony of February 25, 2020	2

New Brunswick OSI Clinic
Exhibit List

EXHIBIT #	DESCRIPTION
P-000244	NB-OSI Clinic - Full File

New Brunswick OSI Clinic
Index

Name of Witness/Title	Tab
Dr. Mathieu Murgatroyd Clinical Psychologist, Addiction and Mental Health Services Horizon Health Network Moncton, NB **Exhibits Referenced:** P-000244 – NB – OSI Clinic – Full File *[Dr. Murgatroyd's reports – NB OSI - Pages 42 – 83; and Pages 24 – 26]* *[Referral, Intake Assessment and Consents - Pages 7 – 23]* *[Recommendation for Ste Anne's Stabilization/Residential Program - Pages 96 – 98]* *[Case Consultation Notes - November 19, 2015 – page 99]* *[Referral to NS OSI – September 30, 2016 – Pages 94 – 95]* *[Letter – December 22, 2016 – re: File Closure – Page 3]*	1
Dr. Anthony Njoku General Adult Psychiatrist Staff Psychiatrist – Operational Stress Injury Clinic and Victoria Health Centre, Fredericton, NB **Exhibit Referenced:** P-000244 – NB – OSI Clinic – Full File *[Dr. Njoku's Patient Progress Notes – August 31, 2015; December 3, 2015; January 4, 2016; January 27, 2016; May 9, 2016 – Pages 28 – 41]*	2

Nova Scotia Community Healthcare Professionals
Exhibit List

EXHIBIT #	DESCRIPTION
P-000076	Individual Psychotherapy Assessment Form
P-000077	Screenshot - Text messages - December 9 and 14, 2016 and January 2, 2017
P-000092	Third Disclosure-Oct 9 2019 from Adam Rodgers
P-000283	Clinical Care Manager (CCM) - Outcomes Agreement
P-000288	Helen Boone - Notes and Consent Documents

Nova Scotia Community Healthcare Professionals
Index

Name of Witness/Title	Tab
Dr. Ranjini Mahendrarajah Family Physician Guysborough Memorial Hospital, Guysborough, NS Guysborough Medical Clinic/Anita Foley Health Services Centre, Guysborough, NS Milford Haven Nursing Home, Guysborough, NS **Exhibit Referenced:** P-000092 – Third Disclosure – October 9, 2019 – from Adam Rodgers *[Dr. Ranjini's records – Guysborough Memorial Hospital Emergency – August 13, 2015; November 2, 2016; December 19, 2016 - Pages 4 – 5; 9 – 10; and 18 -19]*	1
Dr. Ali Khakpour Family Physician North York City Centre Medical Clinic Walk-in Clinic, Toronto, ON Family Practice Walk-in Clinic, Toronto, ON Previous employment: Family Medicine Practitioner – Emergency Room Physician and Hospitalist Guysborough Memorial Hospital, Guysborough, NS **Exhibit Referenced:** P-000092 - Third Disclosure – October 9, 2019 – from Adam Rodgers *[Dr. Khakpour's records – Guysborough Memorial Hospital Emergency - December 13, 2016, December 14, 2016, December 20, 2016] [Pages 14 -15; 16 – 17 and 20]*	2
Dr. Luke Alexander Harnish Locum Physician Guysborough Memorial Hospital, Guysborough, NS Guysborough Medical Clinic/Anita Foley Health Services Centre, Guysborough, NS	3

Exhibit Referenced: P-000092 - Third Disclosure – October 9, 2019 – from Adam Rodgers *[Dr. Harnish's records – Guysborough Memorial Hospital Emergency October 13, 2016 - Pages 7 – 8]*	
Catherine Chambers – Testimony of February 12, 2020 Registered Counselling Therapist The Kamala Institute, Antigonish, NS **Exhibits Referenced:** P-000076 – Individual Psychotherapy Assessment Form P-000077 – Screenshot – Text Messages – December 9 and 14, 2016 and January 2, 2017 *[Text Messages between Lionel Desmond and Catherine Chambers]*	4
Catherine Chambers – Testimony of February 13, 2020	5
Helen Luedee Manager, Opiate Recovery Program, Mental Health and Addictions Eastern Zone – Nova Scotia Health Authority, NS Helen Boone, Counselling & Consulting Services (Owner, Operator) Social Worker, NS **Exhibits Referenced:** P-000288 – Helen Boone – Notes and Consent Documents P-000283 – Clinical Care Manager (CCM) – Outcomes Agreement	6

St. Martha's Regional Hospital – Antigonish, NS
Index

Name of Witness/Title	Tab
Dr. Justin Clark Emergency Medicine Physician Colchester East Hants Health Centre, Truro, NS Dartmouth General Hospital, Dartmouth, NS St. Martha's Regional Hospital, Antigonish, NS **Exhibit Referenced:** P-000067 - St. Martha's Regional Hospital Chart *[Emergency Chart – January 1, 2017 - Pages 32 – 40]*	1
Dr. Faisal Rahman – Testimony of February 4, 2020 Chief of Psychiatry Eastern Zone, Nova Scotia Health Authority, NS **Exhibits Referenced:** P-000067 – St. Martha's Regional Hospital Chart *[Emergency Chart – January 1 and 2, 2017 – Pages 32 – 40]* P-000108 - Chart Notes from Dr Rahman P-000105 - Suicide Risk Assessment Intervention Policy *[Nova Scotia Health Authority]*	2
Dr. Faisal Rahman – Testimony of February 5, 2020	3
Dr. Ian Slayter Staff Psychiatrist, St. Martha's Regional Hospital, Antigonish, NS Assistant Professor, Dept. of Psychiatry, Dalhousie University, Halifax, NS Co-Chair, Eastern Zone Mental Health Quality Council, Sydney, NS **Exhibits Referenced:** P-000069 - History of Visits dated October 24, 2016 to January 4, 2017 *[St. Martha's Regional Hospital]*	4

P-000071 - Psychiatric Consultation Report regarding PTSD by Dr. Slayter dated December 2, 2016 P-000072 - Letter dated December 2, 2016, from Dr. Slayter recommending regular participation in a gym and in yoga P-000067 – St. Martha's Regional Hospital Chart *[Emergency Chart – October 24, 2016 – December 1, 2016 - Pages 4 – 10; Pages 11 – 13; Pages 22 – 25; Pages 26 – 28]*	
Heather Wheaton – Testimony of February 10, 2020 Registered Nurse – Nova Scotia Health Authority, Mental Health Crisis Clinician (including term assignments as Crisis Coordinator) St. Martha's Regional Hospital, Antigonish, NS **Exhibits Referenced:** P-000067 – St. Martha's Regional Hospital Chart *[Emergency Chart - October 24, 2016 – Pages 7 – 10]* P-000113 - New Risk Assessment *[Crisis Response Service Mental Health/Risk Assessment]* P-000105 - Suicide Risk Assessment Intervention Policy *[Mental Health and Addictions Policy and Procedure Suicide Risk Monitoring]*	5
Heather Wheaton – Testimony of February 11, 2020	6
Lee Anne Watts Registered Nurse St. Martha's Regional Hospital, NS **Exhibit Referenced:** P-000067 - St. Martha's Regional Hospital Chart *[Emergency Chart – January 1 and 2, 2017 – Pages 34 – 35 and Pages 40-41]*	7
Maggie Mary MacDonald Registered Nurse St. Martha's Regional Hospital, NS	8

Exhibit Referenced: P-000067 - St. Martha's Regional Hospital Chart *[Emergency Chart – January 1 and 2, 2017 – Page 34 and Pages 36 – 37]*	
Ellen MacDonald Registered Nurse – Emergency Department St. Martha's Regional Hospital, Antigonish, NS **Exhibit Referenced:** P-000067 - St. Martha's Regional Hospital Chart *[Emergency Chart – December 1, 2016 – Pages 22 - 24]*	9
Amy Mary Collins Registered Nurse St. Martha's Regional Hospital, Antigonish, NS **Exhibit Referenced:** P-000067 - St. Martha's Regional Hospital Chart *[Emergency Chart – January 1 and 2, 2017 Page 35]* *[Emergency Chart – December 1, 2016 Page 22]*	10
Joan Hines Medical Secretary Adult Outpatient Mental Health and Addictions St. Martha's Regional Hospital, NS **Exhibit Referenced:** P-000110 - St. Martha's Appointment Data Base	11

RCMP
Exhibit List

EXHIBIT #	DESCRIPTION
P-000018-A	Lionel DESMOND Homicide Investigation - Investigational Synopsis (Pg 3-29)
P-000031	1 Page Occurrence Summary November 18, 2015
P-000032	1 Page Supplemental Report A. MacCallum, November 18, 2015
P-000033	2 Page Report Past Occurrence November 18, 2015
P-000034	1 Page Report Past Occurrence November 18, 2015
P-000081	Open Source Intelligence Brief Sean Hughes January 5, 2017
P-000082	Notes and Reports - Cst. Richard N.B. November 27, 2015 and Seized Firearms
P-000083	N.B. RCMP Reports November 27, 2015 Suicide Threat and Seized Firearms
P-000084	January 4, 2017 RCMP Document Summary November 27, 2015 Occurrence
P-000086	November 25, 2016 RCMP Occurrence Report Desmond
P-000087	November 28, 2015 Report Desmond and Seized NS Firearm
P-000088	November 28, 2015 Report Complaint from Richard Borden
P-000089	Handwritten Notes Cst. Len MacDonald 2015-2016 Desmond
P-000099	A to W - Extraction Report

RCMP
Index

Name of Witness/Title	Tab
Corporal Gerald Rose-Berthiaume RCMP Officer Nova Scotia Major Crime Unit, Debert, NS **Exhibit Referenced:** P-000018-A - Lionel DESMOND Homicide Investigation - Investigational Synopsis *[January 3, 2017 – RCMP General Report/Investigation - Pages 3 - 29]*	1
Staff Sergeant Addie Maccallum RCMP Officer District Commander in Pictou Co., NS Previously Stationed: RCMP Officer District Commander in Guysborough Co., NS **Exhibits Referenced:** P-000031 – 1 Page Occurrence Summary November 18, 2015 *[November 18, 2015 - RCMP Report Wellness Check Lionel Desmond]* P-000032 - 1 Page Supplemental Report A. MacCallum, November 18, 2015 *[November 18, 2015 - RCMP Report Wellness Check Lionel Desmond]* P-000033 - 2 Page Report Past Occurrence November 18, 2015 *[November 18, 2015 - RCMP Report Wellness Check Lionel Desmond]* P-000034 - 1 Page Report Past Occurrence November 18, 2015 *[November 18, 2015 - RCMP Report Wellness Check Lionel Desmond]*	2

Constable Burns Anderson RCMP Officer Canso Detachment, Guysborough Co., NS **Exhibit Referenced:** P-000086 – November 25, 2016, RCMP Occurrence Report Desmond *[November 25, 2016 - RCMP Report Lionel Desmond – call reporting wife overdue to return home that marriage is over]*	3
Constable Steven Richard RCMP Officer Oromocto, NB **Exhibits Referenced:** P-000082 - Notes and Reports - Cst. Richard N.B. November 27, 2015, and Seized Firearms *[November 27, 2015 – RCMP Report and Notes - Suicide call and seizure of New Brunswick Firearms – Lionel Desmond]* P-000083 - N.B. RCMP Reports November 27, 2015, Suicide Threat and Seized Firearms *[November 27, 2015 – RCMP Report and Notes - Suicide call and seizure of New Brunswick Firearms – Lionel Desmond]* P-000084 - January 4, 2017, RCMP Document Summary November 27, 2015 Occurrence *[Suicide call and seizure of New Brunswick Firearms]*	4
Constable Leonard MacDonald RCMP Officer Antigonish Detachment, NS Previously Stationed: Canso/Guysborough Detachment, Guysborough Co., NS **Exhibits Referenced:** P-000087 - November 28, 2015, Report Desmond and Seized NS Firearm *[November 28, 2015 – RCMP Report Lionel Desmond upset – wife Shanna Desmond took firearms and marital issues]* P-000088 – November 28, 2015, Report Complaint from Richard Borden	5

[November 28, 2015 – RCMP Report Richard Borden father of Shanna Desmond advises Lionel Desmond on neighbouring property yelling at his home looking for firearms] P-000089 – Handwritten Notes Cst. Len MacDonald 2015-2016 Desmond *[November 28, 2015 – Notes of Cst. Len MacDonald Re: interactions with Shanna Desmond and Lionel Desmond on this date]*	
RCMP Civilian/Member Sean Hughes Criminal Intelligence Analyst RCMP 'H' Division Criminal Analysis Section – Halifax, NS **Exhibit Referenced:** P-000081 – Open Source Intelligence Brief Sean Hughes January 5, 2017	6
RCMP Civilian/Member Gilles Marchand Forensic Analyst RCMP 'H' Division Tech Crime Unit – Halifax, NS **Exhibits Referenced:** P-000099 – A to W – Extraction Report *[A to W Phone Calls, Text Messages, and Search History between May 2015 and January 3, 2017, recovered from Lionel Desmond's phone]*	7

Ste Anne's
Exhibit List

EXHIBIT #	DESCRIPTION
P-000254	Ste. Anne's Hospital - Medical Records
P-000255	Supplemental Documents - Ste. Anne's Hospital Medical Records

Ste Anne's Hospital
Index

Name of Witness/Title	Tab
Dr. Robert Ouellette Psychiatrist, for the Canadian Armed Forces, Valcartier, QC Psychiatrist, Sainte Anne de Bellevue Hospital, Montreal, QC **Exhibit Referenced:** P-000254 – Ste Anne's Hospital – Medical Records *[The translated version – pages 6 – 7; pages 13 – 17; and pages 41 – 49]*	1
Dr. Isabelle Gagnon Psychologist, Operational Trauma and Stress Support Center Department of National Defence, QC **Exhibit Referenced:** P-000254 – Ste Anne's Hospital – Medical Records *[Pages 275 - 306]*	2
Kama Hamilton Social Worker St Anne's Hospital, Residential Treatment Clinic for Operational Service Injuries (RTCOSI) Montreal, QC **Exhibit Referenced:** P-000254 – Ste Anne's Hospital – Medical Records *[Ste Anne's Hospital Interdisciplinary Discharge Summary – pages 268-274]* *[Kama Hamilton's Medical Records – pages 238 – 267]* *[Kama Hamilton's Social Services Reports June 30, 2016, and July 7, 2016]*	3

Julie Beauchesne Adult Psychiatry Ste Anne's Hospital, QC **Exhibit Referenced:** P-000254 – Ste Anne's Hospital – Medical Records *[Julie Beauchesne's Reports - The translated version – pages 350 – 355]*	4
Maria Riccardi Director, Art Therapist, Career Counselor and Psychotherapist Specializing in life transitions, educational challenges and life adjustments, QC **Exhibit Referenced:** P-000254 – Ste Anne's Hospital – Medical Records *[Maria Riccardi's Reports - Pages 356 - 365]*	5
Julie Blondin Mental Health Nurse Ste Anne's Clinic, QC **Exhibit Referenced:** P-000254 – Ste Anne's Hospital – Medical Records *[Nurse Data Collection Reports - Pages 79- 90]*	6

Appendix B

Dr. Peter Scott Theriault

East Coast Forensic Psychiatric Hospital
88 Gloria McCluskey Ave. Room 1416
Dartmouth, NS B3B 2B8

Email: Scott.Theriault@nshealth.ca
Phone: (902) 460-7300

Degrees

2008 - 2009	International Diploma in Mental Health Law and Human Rights - Indian Law Society and World Health Organization
1982	Bachelor of Science, Chemistry - Cum Laude - Dalhousie University
1982 - 1986	Doctor of Medicine - Dalhousie University

Postgraduate Training

1997 - 1998	Fellow in Correctional and Forensic Psychiatry - Queens University
1989 - 1991	Chief Resident in Psychiatry - Dalhousie University - Department of Psychiatry
1987 - 1991	Resident in Psychiatry - Dalhousie University - Department of Psychiatry
1986 - 1987	Rotating Internship [Internship] - Dalhousie University - Department of Psychiatry

Licenses and Credentials

2011 - present	Founder, Forensic Psychiatry - Royal College of Physicians and Surgeons of Canada
2007 - present	Full Licence # 07-03793 - College of Physicians and Surgeons of New Brunswick
2007 - present	Consulting Specialist - College of Physicians and Surgeons of PEI
1991 - present	Fellow (FRCPC) - Royal College of Physicians and Surgeons of Canada
1991 - present	Full Licence - College of Physicians and Surgeons of Nova Scotia
1987 - present	Licentiate - Medical Council of Canada

Faculty Appointments

2006 - present	Associate Professor - Dalhousie University - Department of Psychiatry
2004 - 2006	Assistant Professor - Dalhousie University - Department of Psychiatry
1991 - 2004	Lecturer - Dalhousie University - Department of Psychiatry

Work Experience

2016 - 2021	Deputy Head - Dalhousie University - Faculty of Medicine - Department of Psychiatry
2011 - present	Clinical Director - Nova Scotia Health Authority - Mental Health and Addictions Program - Department of Psychiatry [Clinical Leadership]
2007 - 2011	Clinical Director - Capital District Health Authority - Forensic and Specialty Services - Mental Health Program
2006 - 2007	Interim Director - Capital District Health Authority - Forensic and Specialty Services - Mental Health Program
2003 - 2006	Acting Chief of Psychiatry - Capital District Health Authority
2001 - 2002	Associate Clinical/Academic Director - Capital District Mental Health Program
1998 - 2011	Clinical Director - East Coast Forensic Hospital
1997 - 1998	Psychiatrist - Kingston Psychiatric Hospital - Forensic Service - Kingston, ON
1997 - 1998	Psychiatrist - Correctional Service of Canada - Regional Treatment Center - Ontario
1992 - 1997	Psychiatrist - Kings County Regional Rehabilitation Center - Waterville, NS
1991 - 1997	Psychiatrist - Valley Health Services Association - Kentville, NS
1977 - 1997	Consultant Psychiatrist - Department of Health for Adult Psychiatry

Scientific and Conference Abstracts

1. Teehan M, **Theriault S**. Changing Trends in Forensic Psychiatric Care in Canada. [Poster] Institute on Psychiatric Services (Chicago, USA), October 2002.

2. **Theriault S**. Recent trends in Forensic Services in Canada. [Poster] Institute on Psychiatric Services (Chicago, IL), October 2002.

3. Teehan M, **Theriault S**, Green J, Garnham J, Harding R. Changing Trends in Forensic Psychiatry Care in Canada. [Oral] American Psychiatric Association Annual Meeting (Philadelphia, PA), May 2002.

Books and Chapters

1. **Theriault S** (2013). The Psychiatrist's Role in the Management of Patients on Probation or Parole [Book Chapter]. In: *Law and Mental Disorder, A Comprehensive and Practical Approach.* Irwin Law: Toronto, ON.

Invited Presentations - National and International

1. North-South Partnership for the Promotion of Mental Health (2010) - 6th World Conference on the Promotion of Mental Health and Prevention of Mental and Behavioural Disorders - Washington, D.C.

2. Development of Mental Health Law; Guyana (2009) - International Diploma in Mental Health Law and Human Rights - Pune, India

3. Forensic Psychiatric rehabilitation: Necessity or Naivete? (2007) - MacMaster University - Mountain Health Services - Hamilton, ON

4. Broadening Our Spectrum; Psychosocial Rehab in a Forensic Population (2002) - International Association of Psychosocial Rehabilitation Services - Toronto, ON

5. Dealing with the Emotional Disturbed Offender (2002) - Canadian Association of Police Educators - Halifax, NS

6. Application of Psychosocial rehab in an inpatient setting (2001) - Florida State Hospital - Hollywood, FL, USA

7. Psychosocial rehab and the Forensic Patient (2001) - Mental Health Directors, State of Virginia - USA

8. Assessment and Management of the Mentally ill Offender (2001) - Canadian Congress of Criminal Justice - Halifax, NS

9. The Psychosocial Rehabilitation of the Forensic Patient (2001) - International Association of Forensic Mental Health Services - Vancouver, BC

Invited Presentations - Regional and Local

1. Civil v. Forensic Assessment (2011) - Conference on Policing and Mental Health - Halifax, NS

2. management of Aggression and Agitation (2010) - Conference - Georgetown, Guyana

3. Forensic Refresher (2009) - New Brunswick Psychiatric Association - NB

4. Human Rights Oriented Mental Health Legislation (2009) - Conference - Georgetown, Guyana

5. Mental Health Legislation: Lessons from the Nova Scotia Context (2007) - Conference - Trinidad and Tobago

6. Update on Mood disorders and Anxiety for Family Practitioners (2007) - Dalhousie University - Halifax, NS

7. The Involuntary Psychiatric Treatment Act (2006) - Dalhousie University Annual Refresher Course for Family Practice - Halifax, NS

8. Management of Agitation (2006) - Dalhousie University - Continuing Education Program - Halifax, NS

9. Proposed Improvements in Mental Health Care in Nova Scotia (2005) - Schizophrenia Society of Nova Scotia Annual Conference - Halifax, NS

10. Mental Health Legislation in Nova Scotia (2005) - Nova Scotia Dept. of Health - Halifax, NS [Symposium]

11. Recommended changes to the hospitals Act (2003) - NSH Academic Day - Halifax, NS

12. The Emotionally Disturbed Suspect (2001) - Dept. of Justice, Negotiators Course - Halifax, NS

13. Psychosocial rehab and the Forensic Patient (2001) - Psychosocial Rehab in NS - Halifax, NS

14. Dealing with the Emotionally Disturbed Individual (2001) - HRM Police - Halifax, NS

15. Review of Forensic Services in NS (2000) - Public Prosecution Annual Conference - Halifax, NS

16. Review of Forensic Services in NS (1999) - NS Judiciary Annual Conference - Halifax, NS

Media Interviews

February 2017	CBC [TV] - NSHA - View here

Awards and Recognition

2011	Founder, Forensic Psychiatry - Royal College of Physicians and Surgeons of Canada
1998	Detweiler Travelling Scholarship - Royal College of Physicians and Surgeons of Canada
1983	E. Walter Todd Scholarship - Dalhousie University
1982	E. Walter Todd Scholarship - Dalhousie University
1982	Belle Crowe Scholarship in Chemistry - Dalhousie University
1981	Continuing Scholarship - Dalhousie University
1981	Belle Crowe Scholarship in Chemistry - Dalhousie University
1980	Ross E. Faulkner Entrance Scholarship - Dalhousie University
1980	Continuing Scholarship - Dalhousie University
1979	Ross E. Faulkner Entrance Scholarship - Dalhousie University

Committee Membership

2018 - 2021	Senate [Member] - Dalhousie University
2017 - 2020	Professionalism Committee [Member] - Faculty of Medicine
2016 - present	Mental Health Quality Council [Member] - NSHA
2016 - present	Finance Committee [Chair] - Department of Psychiatry
2014 - 2015	Chiefs of Psychiatry of Nova Scotia [Member] - Other External
2014 - present	Involuntary Psychiatric Treatment Act Committee [Member] - NSHA
2013 - 2014	CHAMHP Leadership Committee [Member] - NSHA
2013 - present	Mental Health Quality Steering Committee [Co-Chair] - NSHA
2012 - present	Mental Health & Addictions Leadership Team [Member] - NSHA
2012 - 2014	Concurrent Disorders Task Force [Member] - NSHA
2012 - 2013	Mental Health Program Leadership Council [Member] - NSHA

2012 - 2014	Mental Health Quality Steering Committee [Member] - NSHA
2012 - 2014	Recovery and Integration Project Steering Committee [Member] - NSHA
2012 - 2013	Transitional Leadership Team Committee [Member] - NSHA
2012 - 2016	AFP Negotiating Committee [Member] - Department of Psychiatry
2012 - 2015	Quality Council Leadership Committee [Member] - NSHA
2011 - present	Human Resources Committee [Member] - Department of Psychiatry
2011 - present	Executive Committee [Member] - Department of Psychiatry
2011 - present	Concurrent Disorder Clinical Initiatives Working Group [Member] - NSHA
2011 - 2012	Concurrent Disorders Council [Member] - NSHA
2011 - 2014	Mental Health Clinic Manager Committee [Member] - NSHA
2011 - 2012	Mental Health Program Leadership Council [Member] - NSHA
2011 - 2014	Morbidity & Mortality Committee (Various Groups) [Member] - NSHA
2011 - 2012	Investigations Committee [Member] - College of Physicians and Surgeons of Nova Scotia
2011 - 2013	Finance Committee [Member] - Department of Psychiatry
2011 - 2018	Specialty Committee [Member] - Royal College of Physicians & Surgeons of Canada
2010 - present	Mental Health & Addictions Leadership Team [Member] - NSHA
2010 - present	CBD Working Group [Member] - Royal College of Physicians and Surgeons of Canada
2010 - 2018	Working Group for Subspecialization Standards in Forensic Psychiatry [Member] - Royal College of Physicians and Surgeons of Canada
2008 - 2013	College of Physicians and Surgeons of Nova Scotia Investigation Committee [Member] - Other External
2007 - present	Involuntary Psychiatric Treatment Act Committee [Co-Chair] - NSHA
2003 - 2006	District Medical Advisory Committee [Member] - NSHA
2000 - 2001	council [Member] - College of Physicians and Surgeons of Nova Scotia
1999 - 2015	Program Advisory Council [Member] - Nova Scotia Hospital
1999	Working Group for the Revision of the Hospitals Act, Law Reform [Member] - Commission of Nova Scotia
1998 - 2015	Joint Forensic Committee [Member] - Department of Justice/Health
1998 - 2003	Medical Advisory Counsil [Member] - Nova Scotia Hospital

1997	Ethics Steering Committee [Member] - Western Regional Health Board
1996 - 1997	Ethics Committee [Member] - Kings County Regional Rehabilitation Center
1995 - 1997	Clinical Appraisal Committee [Member] - Valley Regional Hospital
1994 - 1997	Board of Directors [Member-at-large] - Schizophrenia Society of Nova Scotia
1992 - 1993	Committee on Economics and Management [Member] - Canadian Psychiatric Association
1991 - 1993	Medical Advisory Council [Member] - Valley Regional Hospital

Scientific Review

2016 - present	Reviewer - Canadian Journal of Psychiatry [Journal]

Service and Advocacy

2016 - present	Department of Health and Wellness - Leadership Meetings [Leader]

Professional Association Memberships

2002	Nova Scotia Psychiatric Association [President]
1991 - present	American Association for Psychiatry and the Law
1991 - present	Nova Scotia Medical Legal Society
1991 - present	Nova Scotia Medical Society
1991 - present	Canadian Association for Psychiatry and the Law
1991 - present	Canadian Psychiatric Association

Continuing Professional Development

1. 2019: Just Culture in Healthcare Certification Course [Certificate] - Saegis, CMPA
2. 2019: XXX W.O. McCormick Academic Day Conference, May 10, 2019, 'Do we have your attention?: ADHD and more...' (Section 1 - 5.75 Credit hrs) - Dalhousie DoP CPD, educationally co-sponsored by the Dalhousie CPD Office
3. 2018: XXIX W.O. McCormick Academic Day Conference, April 27, 2018 - Dalhousie DoP CPD, educationally co-sponsored by the Dalhousie CPD Office
4. 2017: Psychopharmacology review
5. 2016: Canadian Psychiatic association annual meeting
6. 2016: Teaching and assessing critical thinking (TACT II) - Dalhousie CPD
7. 2005: Levels III/IV - Physician Management Institute

8. 2003: Level II - Physician Management Institute
9. 2001: Management Program for Clinical Leaders
10. 1999: Level I - Physician Management Institute

Tab 8

Acronyms

ACRONYMS

AC	Area Counsellor
ACT	Acceptance and Commitment Therapy
ACMHAC Addictions Services	Adult Community Mental Health and
ADR	Alternate Dispute Resolution
ARMEL Limitations	Administrative Review Medical Employment
ANS	African Nova Scotians
AO	Administrative Officer
Ba	Behavioural Activation
BHSOL	Benefits Health Services OnLiine
CAF	Canadian Armed Forces
CBRP	Cape Breton Regional Police
CCM	Clinical Care manager
CF	Canadian Forces
CFMAP	Canadian Forces Member Assistance Program
CFIS	Canadian Firearms Information System
CFO	Chief Firearms Officer
CFP	Canadian Firearms Program
CFMVRCA	Canadian Forces Members and Veterans Re-establishment and Compensation Act
COA	Counsel of Accreditation
CM	Case Manager
CMA	Case Manager Assessment
CMS	Case Management Services
CNCI	Case Need and Complexity Indictors
CPT	Cognitive Processing Therapy

CPIC	Canadian Police Information Centre
CPO	Chief Petty Officer
CPT	Cognitive processing therapy
CSDN	Client Service Delivery Network
CSTM	Client Services Team Manager
DA	Disability Award
DECH	Dr. Everett Chalmers Regional Hospital
DX	Disability Exam
DV	Domestic Violence
DVRM	Domestic Violence Risk Management
ED	Emotional Disability
EED	Equity and Engagement Division
EHS	Emergency Health Services
EMA	Emergency Management Act
EMDR	Eye Movement Desensitization Reprocessing
EPOHD Health	Emergency Preparedness and Occupational Directorate
f/u	Follow-up
FIP	Firearms Interest Police
FOIPOP Privacy	Freedom of Information and Protection of
FSENS	Family Services of Eastern Nova Scotia
HAAC	Health Association of African Canadians
HI	Homicide Ideation
HO	History of
HPO	Health Protection Act
HRPD	Halifax Regional Police Department
HRT	Health Related Travel
HV/HI	History of Violence/Homicidal Ideation

Hx	Prescription history
IDT	Interdisciplinary Team
IPT Act	Involuntary Psychiatric Treatment Act
IPV	Intimate Partner Violence
MAP	Member Assistance Program
Mbr	Member
MDD	Major Depressive Disorder
MDE	Major Depressive Episode
MEL	Medical Employment Limitations
MH	Mental Health
MHO	Mental Health Officer
MO	Medical Officer
MTC	Marijuana for Trauma Clinic
MyVAC	My Veterans Affairs Account
NBCFO	New Brunswick Chief Firearms Officer
NCCN	National Contact Centre Network
NSHA	Nova Scotia Health Authority
OSC	Operational Stress Clinic
ODARA	Ontario Domestic Assault Risk Assessment
OCD	Obsessive Compulsive Disorder
OIPC	Office of the Information and Privacy Commission for Nova Scotia
OPOE	One Person One Experience
OPOR	One Patient One Record
OS	Occupational Stress
OSI	Operation Stress Injury
OSISS	Operational Stress Injury Social Support
OT	Occupational Therapist
OTSSC	Operational Trauma and Stress Support Centre

P-Cat	Permanent Categories
PAL	Possession and Acquisition License
PEACE	Program for Experiencing Anger with Control and Effectiveness
PE	Prolonged Exposure (?)
PET	Prolonged Exposure Therapy
PHIA	Personal Health Information Act
PRN's	Pro re nata "as needed"
PRT	Physical Rehabilitation Therapist
PT	Patient
PTBS	Post Traumatic Brain Disorder
PTSD	Post Traumatic Stress Disorder
AQ	Quality Assurance
RCMP	Royal Canadian Mounted Police
RMHO	Regional Mental Health Officer
RROD	Rehabilitation Record of Decision
RO	Rule Out
RRIT	Regina Risk Indicator Tool
RTCOSI Stress	Residential Treatment Clinic for Operational Injuries
SHSD	Specialized Health Services Directorate
SI	Suicidal Ideation
SO	Senior Officer
SR	Suicidal Risk
SRAI	Suicide Risk Assessment Intervention
SW	Social Worker
T-CAT	Temporary Category
TBI	Traumatic Brain Injury

TFP	Trauma focused Psychotherapy
TX	Treatment
UCR	Uniform Crime Reporting
VO	Veteran's Affairs
VAC	Veterans Affairs Canada
VIS	Violence Intervention Service
VSTM	Veteran Services Team Manager
WHPSP	Workplace Health and Public Safety

Tab 9

List of Recommendations

APPENDIX 9

List of Recommendations

RECOMMENDATIONS

1. Recommendation: It is recommended that the Province of Nova Scotia advocate the Federal Government to have a case manager assigned to Veterans transitioning out of the Canadian Armed Forces.

2. Recommendation: That the Rapid Access and Stabilization Program be funded by the Province of Nova Scotia to include all regions in Nova Scotia.

3. Recommendation: That the Province of Nova Scotia liaise with federal agencies to ensure individuals diagnosed with Post Traumatic Stress Disorder or other health issues be provided a copy of their health records to be ingested into Nova Scotia records.

4. Recommendation: That the Nova Scotia Health Authority and the Nova Scotia Department of Health and Wellness assess the availability of neuropsychological assessments in the province and, if needed, take steps to ensure they are more readily available.

5. Recommendation: That the Nova Scotia Health Authority continue to update its Suicide Risk Assessment & Intervention policy and tool based on the most up-to-date evidence on suicide risk assessment and continue to train staff engaged in mental health on the SRAI policy and tool and be provided adequate funding by the Province of Nova Scotia to do so.

6. Recommendation: That the Nova Scotia Department of Health and Wellness and the Nova Scotia Health Authority partner with appropriate community organizations to provide more comprehensive virtual care to rural African Nova Scotian communities.

7. Recommendation: That the Nova Scotia Department of Health and Wellness and the Nova Scotia Health Authority take steps to recruit Black and diverse mental health providers to provide culturally informed and responsive care with an emphasis on training in the areas of psychosocial services, occupational stress, and general mental health and addictions with appropriate provincial funding.

8. Recommendation: The Nova Scotia Department of Health and Wellness and the Nova Scotia Health Authority should recruit and provide educational scholarships for Black registered nurses and nurse practitioners with appropriate provincial funding.

9. Recommendation: The Network of Black Mental Health Providers built from the work of the Nova Scotia Mental Health and Addiction Strategy should be supported and adequately resourced by the Province of Nova Scotia.

10. Recommendation: The Province of Nova Scotia should ensure that funding for the Men's Helpline through the provincial 211 system continue, and work to increase public awareness of websites that provide information for those who encounter intimate partner violence.

11. Recommendation: That the Province of Nova Scotia embark on a public information campaign across multimedia regarding avenues to access programs relating to intimate partner violence. Further, that any campaign be aware of, and refer to, African Nova Scotian needs and cultural identity.

12. Recommendation: Ensure that frontline professionals in multiple systems such as health, mental health, education, social services, and the justice system, are up to date with current information about intimate partner violence, the dynamics in these relationships, the impact of intimate partner violence on children and the potential for lethality in these cases. This should include an awareness of risk factors, risk assessment, safety planning and risk management strategies.

13. Recommendation: That Nova Scotia institute a police standard requiring all police agencies to utilize an intimate partner violence risk assessment tool in all calls and investigations involving domestic conflict where concerning behaviour regarding an intimate partner is present irrespective of the existence of a criminal charge.

14. Recommendation: That the Nova Scotia Departments of Justice and Community Services review the High-Risk Case Coordination Protocol to deal with cases in which there is no criminal offence but there is concerning behaviour related to the intimate partner.

15. Recommendation: That Nova Scotia's Chief Firearms Officer work with other provinces to ensure that processes are in place to notify when clients of this and other provinces are involved in events that create FIPs and to ensure that information is shared in a timely manner.

16. Recommendation: That police officers in Nova Scotia receive additional training on proper Uniform Crime Report coding.

17. Recommendation: That the Province of Nova Scotia advocate with the Federal Government to have federal policing agencies provide firearms officers access to the federal police database (PROS).

18. Recommendation: That the Province of Nova Scotia ensure all steps be taken to have expedited access by the Chief Firearms Officer to various police databases, including PROS, Versades and Niche.

19. Recommendation: That the Province of Nova Scotia encourage the Federal Government to proclaim in force those provisions of Bill C-71, an Act to amend certain Acts and Regulations to firearms, s.c. 2019, c.9, related to licence verification and business record keeping.

20. Recommendation: That the Province of Nova Scotia advocate the Federal Government to add under section 16(a) of the Application for a Possession and Acquisition Licence under the Firearms Act a provision that applicants must disclose any employment restrictions regarding firearms or weapons.

21. Recommendation: An applicant for a firearms licence or a renewal of a firearms licence should be required to give an enduring consent and direction to the Office of the Chief Firearms Officer to allow follow-up with a medical practitioner at any time during the period that the licence is valid and in effect and to require the medical practitioner to report changes in the health status of the applicant.

22. Recommendation: The Office of the Chief Firearms Officer should, in appropriate cases, place certain licences under review and seek additional medical information, if necessary, to ensure that applicants who have been granted licences are continuing to meet eligibility requirements and are maintaining good mental health.

23. Recommendation: The Office of the Chief Firearms Officer should receive additional funding to facilitate additional and ongoing checks of the mental health status of licensees.

24. Recommendation: That the Province of Nova Scotia liaise with other provinces and the Federal Government to improve the transfer of health records into each others record databanks.

25. Recommendation: To ensure that the recommendations from this Inquiry are not lost in the passage of time, the Province of Nova Scotia should create a formal implementation committee comprising of senior government officials from relevant departments to oversee the implementation of the Inquiry's recommendations. This committee should have at minimum a five-year mandate and liaise with appropriate federal departments.

REPORT OF THE INQUIRY

INTO THE DEATHS OF THE DESMOND FAMILY

VOLUME III

Master Timeline

Desmond Fatality Inquiry

Master Timeline

Legend	
Canadian Armed Forces Dr. Vinod Joshi Dr. Wendy Rogers	
Cathrine Chambers Helen Boone Family Service of Eastern Nova Scotia	
Family Witnesses Shonda Borden, Chantel Desmond, Ricky Borden, Thelma Borden, Kenny Greencorn	
Firearms	
Guysborough Medical Clinic Dr. Ranjini Mahendrarajah Dr. Luke Harnish Dr. Ali Khakpour	
Dr. Erik Mont	
Naomi Society	
New Brunswick OSI	
Nova Scotia OSI Natasha Tofflemire	
Quebec Ste. Anne's	
RCMP	
Dr. Paul Smith	
St. Martha's Regional Hospital Dr. Ian Slayter Dr. Faisal Rahman Dr. Justin Clark, Leanne Watts, Maggie MacDonald Joan Hines Ellen MacDonald, Amy Collins	
Veterans Affairs Canada and Canadian Armed Forces	

Master Timeline -

Date	Description	Source Page(s)
September 23, 2004	Lionel Desmond joins the Canadian Armed Forces (CAF) and is posted to the 2nd Battalion of The Royal Canadian Regiment based in CFB Gagetown, New Brunswick.	
January – August 2008	Lionel Desmond is deployed to Kandahar province, Afghanistan. In August, Lionel Desmond returned to CFB Gagetown, New Brunswick.	
December 29, 2008	Lionel Desmond completed his first application for a non-restricted firearms Possession and Acquisition Licence (Application # 0047422292). The application is signed and dated by Shanna Desmond on December 29, 2008. Lionel Desmond's listed references include Richard Pitchuck and Shonda Borden. Desmond responded "No" to all six (6) Personal History Questions including "No" to: *"During the past five (5) years, have you threatened or attempted suicide, or have you suffered from or been diagnosed or treated by a medical practitioner for: depression; alcohol, drug or substance abuse; behavioural problems; or emotional problems?"* *"During the past two (2) years, have you experienced a divorce, a separation, a breakdown of a significant relationship, job loss or bankruptcy?"*	Exhibit P-000130 [pages 17 – 20] Exhibit P-000131 [page 1] Exhibit P-000130 [page 18]
January 5, 2009	Lionel Desmond's December 29, 2008, application for a non-restricted firearms Possession and Acquisition Licence is received by the Canadian Firearms Program (CFP) on January 5, 2009.	Exhibit P-000130 [pages 17 – 20]
January 15, 2009	Lionel Desmond's application for a firearms Possession and Acquisition Licence is approved/issued less than two (2) weeks after it is received by the Canadian Firearms Program (CFP) on January 15, 2009, and records indicated "No eligibility issues found with the application." The licence expiry date was noted as November 21, 2014.	Exhibit P-000130 Exhibit P-000131 [page 1]

2010	Lionel Desmond is assigned to the musical pipe-and-drum unit.	
September 28, 2011	Lionel Desmond is referred to Dr. Vinod Joshi, a psychiatrist, who meets with him for the purposes of a psychiatric assessment. In his report Dr. Joshi describes Lionel Desmond's chief complaint as follows: *"Cpl Desmond presents with first episode for the last three and a half to four years duration of not feeling very well. He reports a change in his personality, not able to go out of house, not able to go into crowded places such as malls. He hasn't been to a grocery store for a very long period of time. He is not able to sleep well, he experiences recurrent nightmares including sweating. He remembers incidents in Afghanistan especially about carrying body bags and many other incidents that he witnessed. He is isolating himself and has lost motivation or interest to contact family or friends. He feels emotionally detached. He experiences increased anger outbursts and irritability. He has flashes of reliving experiences from overseas. Cpl Desmond decided to seek help at the persuasion of his wife."* Dr. Joshi diagnosed Lionel Desmond with Post-Traumatic Stress Disorder with Major Depressive Episode (operational). This is the first time that Lionel Desmond is formally diagnosed with PTSD. Dr. Joshi also notes that there are marital difficulties. Dr. Joshi prescribed medications. Dr. Joshi observed that Lionel Desmond had very limited understanding of PTSD and referred him to the Trauma Focused Psychotherapy and Psychoeducational Group. Dr. Joshi intended to see Lionel Desmond on a regular ongoing basis, initially on a two-to-three (2-3) week basis, and once established with a therapist less frequently.	Exhibit P-000183 [pages 1, 3 and 4]
2011 - 2015	Dr. Joshi would see Lionel Desmond 32 to 33 times during this period of time. His presentation, condition and symptoms would vary during this time.	Transcript February 23, 2021 [page 75]
October 5, 2011	Lionel Desmond sees Dr. Joshi. He is taking his medications but continues to have disturbed sleep.	Exhibit P-000188

December 1, 2011	Lionel Desmond has his first session with Dr. Wendy Rogers, a psychologist. Dr. Rogers was experienced in treating PTSD using evidence-based techniques which include Prolonged Exposure Therapy, Cognitive Processing Therapy and Eye Movement Desensitization Reprogramming (EMDR). Dr. Rogers' initial impression of Lionel Desmond was as follows: *"Yes, his depression symptoms were marked. Like he had what we call constricted affect. He didn't show much emotion on his face, his voice was soft, it was slow. Even movement's a little slower, not much animation in his voice. And his symptom severity we typically would measure that every session or every second session. His severity was at least in the moderate range with the instrument we used at the time."* Dr. Rogers' treatment plan was: *"To begin with Behavioral Activation and then to blend PE and CPT interventions. The client does not have a means of listening to recordings of sessions, yet reading/writing is difficult for him, and therefore the trauma-focused part of therapy will present a challenge."* Dr. Rogers planned to see Lionel Desmond on a weekly basis going forward.	Exhibit P-000232 Transcript February 24, 2021 [page 48] Exhibit P-000232 Transcript February 24, 2021 [page 62]
Late 2011/Early 2012	According to a January 27, 2012, document completed by Nurse Practitioner Janet Weber, Lionel Desmond continues to see Dr. Joshi monthly and Dr. Rogers weekly.	Exhibit P-000219
April 26, 2012	Lionel Desmond is described by Dr. Rogers as "beginning to respond to treatment, albeit slowly."	Exhibit P-000234
May 3, 2012	Lionel Desmond sees Dr. Joshi. He is not doing well. He continues to have significant PTSD symptoms and continues to show only modest improvement.	Exhibit P-000190

July 31, 2012	Dr. Joshi notes that Lionel Desmond continues to experience PTSD symptoms with disturbed sleep.	Exhibit P-000192 [page 1]
October 2, 2012	Dr. Joshi observes that Lionel Desmond is not doing well. There are marital problems and he feels overwhelmed.	Exhibit P-000193 [page 1]
October 11, 2012	In a Psychology Progress Note, Dr. Rogers noted that the focus of the session was marriage and stated: "Cpl Desmond refused to sign the divorce papers delivered to him."	Exhibit P-000236
October 28, 2012	In a letter to Veterans Affairs Canada (VAC), Dr. Joshi states: *"When reviewed in late spring and early fall of 2012, he continues to have significant problems with PTSD symptoms. They have gotten worse by his wife deciding to separate from him. Cpl Desmond continues to attend psychotherapy. His long term prognosis is guarded in light of poor response to treatment until October 2012."*	Exhibit P-000184 [page 3]
November 6, 2012	Lionel Desmond continues not to do well according to Dr. Joshi. His wife visits but they fight a lot.	Exhibit P-000194 [page 1]
November 15, 2012	Dr. Rogers notes in the Psychology Progress Note that Lionel Desmond has continued with prolonged exposure therapy and that "His distress levels have decreased markedly, and he was able to manage his distress well and to distract himself after the imaginal exposure." Dr. Rogers indicates that she will contact the MO regarding recommending that Lionel Desmond have the chance to be exposed to the range. She says that he is very close to being able to be removed from TCAT.	Exhibit P-000237
November 29, 2012	Dr. Rogers states that "Treatment is winding down, and Cpl Desmond is ready to get back to doing CF courses."	Exhibit P-000238
December 13, 2012	Dr. Joshi notes some improvement.	Exhibit P-000195

February 19, 2013	Therapy with Dr. Rogers is terminated as Lionel Desmond has completed Prolonged Exposure Therapy for PTSD in the fall of 2012. Dr. Rogers notes that his symptoms have not recurred. Mr. Desmond was able to do a weapons course in the field without being bothered by the combat environment. According to Dr. Rogers he appears ready to be removed from TCAT.	Exhibit P-000222
February 27, 2013	Lionel Desmond is now described by Dr. Joshi as "Doing well."	Exhibit P-000196 [page 1]
April 4, 2013	Dr. Joshi describes Mr. Desmond as "generally doing well."	Exhibit P-000198
July 18, 2013	Desmond is now described as "Not doing very well" by Dr. Joshi and perceives some racial harassment.	Exhibit P-000203 [page 1]
September 10, 2013	Lionel Desmond sees Dr. Rogers as a result of a "Relapse of mood and anxiety symptoms." Dr. Rogers describes Lionel Desmond as follows: *"Cpl Desmond cannot stop ruminating about a series of racial slurs and a particular incident of harassment in May of this year. He gets so angry that he fears that he would hurt someone. So far he has kept a distance from the person, and his unit is taking appropriate steps to address the situation, but he fears being sent back to the field where he would see the person he is most angry at. He has symptoms of re-experiencing, numbing, avoidance and hyperarousal related to this incident (in addition to symptoms of depression)."* Dr. Rogers queried whether this should be classified as an Adjustment Disorder or a traumatic stress reaction.	Exhibit P-000223
September 25, 2013	Lionel Desmond returns to Dr. Joshi for another psychiatric assessment. At this time Mr. Desmond "is feeling extremely stressed in his current work situation." Dr. Joshi reports that he feels his colleagues are making "racial comments." According to Dr. Joshi: *"He fears that he might lose control, get angry and upset at his colleagues. He had expressed and verbalized thoughts that he might hurt his colleagues."*	Exhibit P-000185

	In a medical note on file, a social worker states: *"Mbr seen at MH Intake this am, after presenting to MH Clinic … Mbr continues to feel harassed at work, including racial slurs that are ongoing. Mbr is pt of Dr Joshi (psychiatry) and Dr Rogers (psychology), and is now fearful of his reactions to this perceived harassment. Mbr fears he may hurt someone, if he has to continue working at his unit. Denies any SI; however, could not deny any homocidal* [sic] *tendencies."*	Exhibit P-000240
November 18, 2013	A Complexity Assessment Interview Questionnaire dated November 18, 2013, is completed containing the following entry: *"OSI (PTSD and MDD) Dx in 2011 associated with Afghanistan tour in 2007. Therapy completed in Feb 2013 with a recommendation that the T-Cat could be ended. Dr Joshi (psychiatrist) planned, in Feb 2013 a recommendation to return to fit full duties and gradual reduction of medications.* *Between the summer and Fall of 2013, the mbrs marriage ended and he also experienced work related stress (racial comments) from some superior which resulted in eventual ADR. Mbr experienced distress (thoughts wanting to harm some one)."* Dr. Joshi described his condition as follows: *"So following the incident at workplace with the racial comments, he became extremely symptomatic. So I think, at that time, it was difficult to consider him to go back in the same work environment. So it started to appear that he was not really recovering and stressors were triggering . . . or stressors were causing relapse of his symptoms. Although they may not be as intense as initial presentation, but still it was making things worse. So that time kind of sense started to come that maybe he was kind of not clear recovering and stressors of life were causing setbacks on a regular basis."*	Exhibit P-000187 [page 1] Transcript February 23, 2021 [page 89]
February 27, 2014	Lionel Desmond applied for a firearms Possession and Acquisition Licence renewal (Application # 0062749709). This application was amended to include non-restricted and restricted firearms. References were initially listed as Richard Pitchuck and Shanna Desmond. Lionel Desmond indicated "Yes" that he is currently	Exhibit P-000130 [pages 24 – 27] Exhibit P-000131 [page 1]

	living with his spouse Shanna Desmond. The application is signed and dated by Shanna Desmond on February 27, 2014. Lionel Desmond again responded "No" to all six (6) Personal History Questions including "No" to: *"During the past five (5) years, have you threatened or attempted suicide, or have you suffered from or been diagnosed or treated by a medical practitioner for: depression; alcohol, drug, or substance abuse; behavioural problems; or emotional problems?"* *"During the past two (2) years, have you experienced a divorce, a separation, a breakdown of a significant relationship, job loss or bankruptcy?"* However, there were several issues surrounding this application, which was not formally granted until December 2, 2014, with an expiration date of November 21, 2020.	Exhibit P-000132 [page 1] Exhibit P-000130 [page 25]
March 3, 2014	Lionel Desmond's application for Possession and Acquisition renewal for non-restricted and restricted firearms is received by the Canadian Firearms Program (CFP).	Exhibit P-000130 [pages 32 – 35] Exhibit P-000131 [page 1] Exhibit P-000132 [page 1]
March 27, 2014	Lionel Desmond is notified by the Canadian Firearms Program that Shanna Desmond is an ineligible reference for a Possession and Acquisition Licence. Under Section 3(1)(c) of the Firearms Licences Regulations spouses are not eligible to be references for such applications. Reuben Perreault is later provided as the second reference.	Exhibit P-000130 [pages 31 – 36] Exhibit P-000131 [page 1] Exhibit P-000132 [page 1]
June 2014	Former Chief Firearms Officer for New Brunswick, Derek Eardley, noted that: *"During client's application process in June 2014 the CFP's Enhanced Screening Unit called a reference who advised that the*	Exhibit P-000130 Exhibit P-000131 Exhibit P-000132 [page 1]

	client suffered from Post-Traumatic Stress Disorder (PTSD). This information had not been disclosed on the client's application." *"Reference indicated applicant has PTSD and was diagnosed about 2 years ago."* *"The file was consequently assigned to Chief Firearms Officer (CFO) NB for further review."*	Exhibit P-000136 [page 8] Exhibit P-000132 [page 1]
September 23, 2014	As a result of notice that Lionel Desmond was suffering from Post-Traumatic Stress Disorder (PTSD) a medical assessment form was mailed to him on September 23, 2014. By way of letter New Brunswick Firearms Officer Joe Roper requested Lionel Desmond to indicate why he had not mentioned his PTSD during his application. The letter stated: *"Please also keep in mind that as requested you have not been completely truthful in answering the personal history questions concerning your mental health and it is a violation of Section 106 of the Firearms Act. You will be contacted at some point to explain this inaccuracy or reasoning prior to granting this license."*	Exhibit P-000130 Exhibit P-000131 [page 1] Exhibit P-000132 [page 1] Exhibit P-000136 [page 4]
October 22, 2014	In a medical examination for administrative purposes an attending physician states: "*Member requesting to have paperwork complete for Office of the Provincial Firearms Officer stating that he is fit to have a personal hunting weapon. First encounter for member with writer, typically followed by NP Weber. Member had PCat completed for PTSD with ARMEL decicions* [*sic*] *in May 2014 stating not fit to safely handle a personal weapon.* *Member states that at time of PCat had some passive HI related to racial discrimination at the workplace. States that through treatment he has improved. Denies any Si* [*sic*] *or HI presently. Mood good with current medication regime*."	Exhibit P-000186
November 4, 2014	Dr. Joshi completes the form Medical Assessment by Physician checking the box which states, "**NO**, I have no concerns that the Applicant named above may pose a safety risk to himself/herself or others."	Exhibit P-000136 [page 6]

November 12, 2014	On November 12, 2014, the completed medical assessment form was received by the New Brunswick Firearms "head office." The form was signed and dated by Dr. Vinod Joshi on November 4, 2014. Dr. Joshi simply checked-off the pre-printed box that stated "**NO**, I have no concerns that the Applicant named above may pose a safety risk to himself/herself or others." The form also contained a section labeled "**COMMENTS (required):**". This was not completed, and the Medical Assessment by Physician form lacked any further insight or details into Lionel Desmond's mental health diagnosis, treatment or prognosis. New Brunswick Firearms Officer Joe Roper noted the doctor's handwriting was not legible along with the date in which it was signed. Messages were left for Lionel Desmond to contact and provide clarification.	Exhibit P-000136 [page 6] Exhibit P-000130 [pages 8 – 9] Exhibit P-000131 [page 1] Exhibit P-000132 [page 1]
December 2, 2014	New Brunswick Firearms Officer Joe Roper spoke with Dr. Vinod Joshi by telephone. Joe Roper's database notes indicate: *"I called the doctor who returned my call and advised me he has no problem with Mr. Desmond possessing firearms. He has been treating him for approx. (4 ½) four and a half years and has him medicated. He advises Mr. Desmond has no psychosis and has never mentioned self harm or any violent ideation.* *I also spoke in length with Mr. Desmond regarding his answer to the medical history question and why it was not answered properly. He advises that he and his wife who assisted him in doing the application did not feel this question applied to him. I explained the difference and he agreed in the future that answer would be different.* *At this time the license is being approved."* Lionel Desmond was approved/issued a Possession and Acquisition Licence # 12325681 for non-restricted and restricted firearms. The licence expiration date was November 21, 2020.	Exhibit P-000130 [page 8] Exhibit P-000136 [page 1] Exhibit P-000131 [pages 1 – 2] Exhibit P-000132 [page 1] Exhibit P-000037

2014	Lionel Desmond sees Dr. Joshi several times throughout 2014 and he is generally described by the doctor as "doing well."	
February 2, 2015	Lionel Desmond completes a Patient Assessment Form for patients seeking a medical cannabis prescription. In that form Lionel Desmond says: *"Cannabis helps me sleep better without me waking up continuously through the night also takes my mind off the traumatic events that I have endured in Afghanistan."*	Exhibit P-000140 [pages 21 – 23]
February 4, 2015	Lionel Desmond is assessed by a nurse employed with the Canadian Armed Forces (CAF). He is advised "that he should speak with MH intake to seek counselling." Highlights of the report include: *"Transition:* *Member noted to be increasingly stressed about transition and noted that it is because of his spouse who can't commit to wheter* [*sic*] *or not she wants to remain in the relationship. Spouse is living in NS and going to Nursing School. Member is stressed over finances and wheter* [*sic*] *or not to sell their house which he feels he cannot afford without any financial support from his spouse. Member reports that he is struggling with moving in any direction until his spouse figures out what she wants to do."* There is no indication that this document or the military medical file was ever shared with Lionel Desmond or any other service providers outside of the Canadian Armed Forces (CAF). Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette testified: *"These sort of CAF medical records, we are not, as case managers, privy to accessing those unless it's a specific sort of supporting document for an application for rehab, so . . ."*	Exhibit P-000300 Transcript June 23, 2021 [page 28]
February 18, 2015	Dr. Joshi notes that Lionel Desmond will be released from the Canadian Armed Forces (CAF) in the next four (4) to six (6) months.	Exhibit P-000216

	Mr. Desmond continues to be concerned about his relationship with his wife. He is not sure if she wants to be in the relationship. At this time he is thinking about medical marijuana as he has been approached by other members to try it.	
February 19, 2015	In anticipation of his discharge from the Canadian Armed Forces (CAF), Lionel Desmond attends the Canadian Armed Forces (CAF) base in Gagetown to request a "Rehab application." This is a transitional program offered through Veterans Affairs Canada (VAC) and includes being assigned a case manager. Despite being proactive, Lionel Desmond is told that he is not eligible until his formal release from the Canadian Armed Forces (CAF). Although it is his desire to get a jump on the transition from military to civilian life, he is forced to wait at least four (4) months. Effectively, this is the first delay in assessing what Lionel Desmond's needs will be for a healthy and successful transition to civilian life. Because he is still a member of the military, Veterans Affairs Canada (VAC) is unable to begin the process of assessing, evaluating, and coordinating resources. They are also unable to begin the process of assigning him a case manager.	Exhibit P-000273 [page 20]
April 13, 2015	Lionel Desmond is assessed by a nurse employed with the Canadian Armed Forces (CAF). His file indicates that he will be medically released from Canadian Armed Forces (CAF) on June 26, 2015. Highlights from the report include: 1. *"Member noted that he has decided that he is going to sell the house here despite relationship uncertaintly* [*sic*] *and plans to meet with a Real Estate Agent next week."* 2. *"Member noted that his spouse states* [*sic*] *is still completing her nursing studies in NS and reports that she is still unsure what she wants to do as far as their relationship goes."* 3. *"Member noted that she has do* [*sic*] *an upcoming practicum at the IWK to complete her Nursing Program and is unable to think about anything else at this time. Member noted that he has sought out counselling by himself."* 4. *"Member reports that he was awarded for PTSD with MDD symptoms."*	Exhibit P-000301

	5. *"Member will need to secure a family doctor. Member is aware how to access waitlist and of resource to acess* [*sic*] *care in interim"* 6. *"… he has obtained Rx for Medicinal Marijuanna* [*sic*] *but has not yet obtained as he would have to pay out of pocket for same. Member is still considering for future if VAC will cover upon his release."* There is no indication that this document was ever shared with Lionel Desmond or any other service provider outside of the Canadian Armed Forces (CAF). During her testimony, Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette acknowledged that there would be value in the sharing of this information during transition: *"I can see some value, yes. If the veteran wishes for me to have that information."*	Transcript June 23, 2021 [page 33]
April 16, 2015	Lionel Desmond again attends the Canadian Armed Forces (CAF) base in Gagetown, New Brunswick. On his own initiative and in anticipation of his military release, he requests a "myVAC" enrollment code which will allow him to access a "myVAC" account. This account is a valuable resource offered to veterans by Veterans Affairs Canada (VAC). It contains important information such as available resources, supports, benefits, and the various forms/applications for accessing those services.	Exhibit P-000273 [page 20]
April 16, 2015	Lionel Desmond is described by Dr. Joshi as "Not doing very well" and as "stressed about upcoming medical release."	Exhibit P-000217
Apr. 16, 2015	Canadian Armed Forces (CAF) Psychiatrist Dr. Vinod Joshi formally refers Lionel Desmond's care to the New Brunswick OSI Clinic. Lionel Desmond's address is listed as 6 Coastal Avenue, Oromocto, New Brunswick.	Exhibit P-000244 [pages 13 – 16]
April 21, 2015	Lionel Desmond again attends the Canadian Armed Forces (CAF) base in Gagetown, New Brunswick. He is requesting assistance with access to the "myVAC" account. He is told by representatives that	Exhibit P-000273 [page 20]

		his enrollment code is still active and that he should simply try logging in again.	
May 1,	**2015**	Dr. Vinod Joshi's referral is received at the New Brunswick OSI Clinic.	Exhibit P-000244 [page 8]
May 5, 2015		For the third time in three (3) weeks, Lionel Desmond attends the Canadian Armed Forces (CAF) base in Gagetown, New Brunswick. He is again seeking assistance around the "myVAC" account. He requests another enrollment code. He is still unable to access the account. Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette testified that there is value in a veteran being familiar with the "myVAC" account. She testified the value of such an account is that the veteran will have a better understanding of "how VAC operates because it's not a simple thing to learn." Despite being aware of Lionel Desmond's struggles, mental health diagnosis, and documented cognitive challenges, Marie-Paule Doucette further testified that once she became Lionel Desmond's case manager, she never did discuss the account with him. No inquiries were ever made to determine whether or not he was able to access this account or navigate the program with its many online forms/applications. There is no indication that Lionel Demond ever discussed any difficulties with navigating MYVAC with his Case Manger.	Exhibit P-000273 [page 19] Transcript June 23, 2021 [page 12]
May 7, 2015		Lionel Desmond's New Brunswick OSI telephone triage is completed by Nurse Christine Lillington. Highlights from this triage include: ***"REASON FOR REFERRAL*** *☑ assessment for treatment *And psychiatry* … ***REASON FOR REFERRAL*** *Client's Understanding: unsure - need to continue Services for mental health - not doing well.* …	Exhibit P-000244 [pages 8 – 10 and 81]

	RISK ASSESSMENT *Present thoughts of suicide? Yes □ No ☑ Homicide? Yes □ No ☑* *Have you ever attempted suicide? Yes □ No ☑ When:* *Possession of firearms? Yes ☑ No □ locked cabinet* *…* *Resources in place:* *Aware of emergency resources.* *Comments / Intervention:* *Client denies current SI/HI. Stated has been increasing his drinking to daily x 3 beers. Could become problematic. Using it as mood is "low."* *…* ***<u>Additional notes</u>****:* *Client expressed he is not doing well with mental health. Stressed about upcoming medical release. Wife in NS, client to put house up for sale here in NB and possibly move to Halifax. Client has ↑ drinking. Client wanting to engage in therapy as well as see psychiatry post release.* *…* *Client placed on both waitlist for psychiatry and treatment."*	
	The following note is made by New Brunswick OSI Nurse Christine Lillington: *"Client expressed a decline in his mental health and stressors concerning his release next month. Client stated he has night sweats, low mood and still concerns with his sleep. His wife has remained in school in NS for the past 6 years and he stated they tend to argue a lot causing the long distance relationship to be strained. He plans on putting his home up for sale this week and will move to NS once he sells it."* Mr. Desmond is placed on the New Brunswick OSI wait list for treatment and psychiatry.	Exhibit P-000244 [pages 26 and 81]

May 13, 2015	A National Defence document completed by an RN in relation to Lionel Desmond's pending release from the Canadian Armed Forces (CAF) contains the following: *"**HISTORY OF PRESENT ILLNESS*** *Release Medical* *Infantryman* *Tour Afganistan* [*sic*] 2007 *Reg force, enrolled 2004* *Release date 26 June 2015* *HPI* *31 yr old male with PTSD and MDE* *PCat submitted 2013-02-26* *AR/MELs rendered 2014-05-06* *Dx and started treatment Sep 2011 related to deployment to Afghanistan in 2007* *Discharged from therapy, care by Dr Rogers, processing completed Feb 2013.* *Follows with Dr Joshi q month for Rx and brief checkup* *Stable on Rx Effexor 150mg OD, Zopiclone 10mg hs, Risperidone 2mg hs, Ativan 1mg prn (uses once weekly)* ***PTSD, MDE – both still active, never achieved remission.*** *Referrals in place to OSI clinic.* *C/O psychosocial stressors: house for sale, medical release, not accepted to NBCC due to administrative errors, marital strain with potential for divorce, separated from his y.o. daughter.* *Currently in marital counselling civi side by himself.* *As per member:* ***Status not stable, continues to deteriorate, wants to improve, but struggles with same. Is a "changed person" now.*** *No HI. Last suicidal ideation last one year ago but never any real intent or plan. Tries to continuously apply "self help"."* [Emphasis added]	Exhibit P-000242 [page 1]
May 25, 2015	Lionel Desmond attends for his Canadian Armed Forces (CAF) "Transition Interview." The purpose of this interview is to collect information from the member in order to properly assess, evaluate, and prioritize the member's needs when transitioning to civilian life. The interview also serves to assist in identifying a member's	Exhibit P-000278

	vulnerabilities and sensitivities at the time of release from the Canadian Armed Forces (CAF). The interview identifies what programs and services are best suited for the particular member once released. As part of the interview, the Regina Risk Indicator Tool is administered. The Regina Risk Indicator Tool is used to assist in measuring and monitoring a veteran's probability of successful transition, re-establishment, and rehabilitation. The results are collectively considered along with other source information in an attempt to measure the probability of success at the time the test is administered. Lionel Desmond's score is 14/65 which places him in the "Moderate Risk" category for an unsuccessful transition into civilian life. As well, at page 6 of the Transition Interview document, the answer of "Yes" is recorded to the question of "Is this member at risk for an unsuccessful re-establishment and/or transition difficulties?" Highlights from the Transition Interview include: 1. "Yes" is reported to the question, "Does the member have any mental and/or emotional health concerns or issues?" The following note is made under the question: *"Client rates his mental/emotional health as poor. Client has a DA for PTSD (@35%) and an application in progress for MDD. Client believes he is being medically released from the CF for his PTSD condition."* 2. "Yes" is reported to the question, "Does the member have any concerns about the impact of their physical, mental and/or emotional health issues on the family?" The following note is made under the question: *"Client is married with a daughter, but they are separated. Client noted that spouse/daughter moved to Nova Scotia some time ago while he tries to get better. Client very upset about this and believes the situation does not look good."* *3. "Client notes that his service-related health concerns (mental and physical) greatly reduce the amount/type of activities he can do."*	

4. Lionel Desmond's replies to the following questions are noted:

   a. *"Thinking about the amount of stress in your life, would you say that most days are:*

      Quite a bit stressful"

   b. *"How are you coping with your pending release?*

      Fair"

   c. *"I have close relationships with people I can depend on who provide me with support and a sense of security and well being.*

      Disagree"

5. Based on the following entries, it does not appear as though Lionel Desmond's wife Shanna Desmond was consulted as part of the transition interview process.

   a. "Not applicable" is noted next to the question of "Does the family member have any concerns about the impact of the member's physical, mental and/or emotional health issues on family functioning?"

   b. There is a blank entry under the question of "How does the spouse/partner/family feel about the member's pending release from the service?"

6. Lionel Desmond is noted as not having a family physician.

7. *"Due to client's mental health he advises having difficulty in public places/situations and leaving his home."*

8. *"Client notes he fell on his head while jumping out of a plane, but was never given a Dx. Client states he has trouble remembering things and retaining information. … Client advised he was told it was linked to his PTSD condition."*

9. *"Client's spouse and daughter moved to Nova Scotia and they are separated while client works on getting healthy. Client does not believe they will return."*

	10. *"Client advises having anger and intimacy issues with his spouse (Due to his PTSD and ED)."*	
May 25, 2015	A work item is generated by Veterans Affairs Canada (VAC) through their Client Service Delivery Network (CSDN) system. This internal work item requests that Lionel Desmond be assessed for case management and rehab support. The system entry reads: *"… please refer this case to a Case Manager to determine the need for case management or rehab program support"* Lionel Desmond is not assigned a Veterans Affairs Canada (VAC) case manager until six (6) months after the generation of this initial work item. (November 26, 2015) When asked why it may have taken approximately six (6) months between the initial work item and Lionel Desmond being assigned a case manager, Marie-Paule Doucette testified:	Exhibit P-000290
	a. *"… I understand that there had been some cuts under a previous government and then they were trying to rehire a number of case managers to assist with the demand."*	Transcript June 22, 2021 [page 71]
	b. *"And in just my first year and such we also had a few retirements. So there definitely seemed to be more demand coming in, so veterans, for example, eligible for case management than there were case managers to assign to. And when I arrived in September, training was the focus at least for the first four to five weeks and then assignment slowly started. So that's how I could explain it. But I don't obviously have the official explanation."*	Transcript June 22, 2021 [pages 71 – 72]
June 8, 2015	New Brunswick OSI Psychologist Dr. Mathieu Murgatroyd contacts Lionel Desmond for the first time. An initial appointment is scheduled for June 22, 2015.	Exhibit P-000244 [page 83]
June 10, 2015	Lionel Desmond phones the New Brunswick OSI Clinic. He will be "out of town" on July 6, 2015, and requests that his first Dr. Njoku psychiatry appointment be rescheduled.	Exhibit P-000244 [page 25]

June 16, 2015	Dr. Joshi states that Lionel Desmond is getting released next Friday and has "Normal anxiety" about future job prospects and money. He is uncertain about his relationship with his wife and "her intentions about their relationship."	Exhibit P-000218
June 22, 2015	**<u>Missed New Brunswick OSI Appointment #1</u>** Lionel Desmond does not show up for his first scheduled appointment with Dr. Mathieu Murgatroyd. Dr. Murgatroyd initiates contact with Lionel Desmond who apologizes for missing the appointment. **<u>Continuity of Care Gap #1: 2 months (April 16, 2015, to June 24, 2015)</u>** It should be noted that two (2) months have passed in this critical transition period from military to civilian life. Other than the single May 7, 2015, New Brunswick OSI intake assessment, Lionel Desmond has not had contact or treatment with mental health professionals over this two-month period.	
June 24, 2015	**<u>Therapy Session #1 New Brunswick OSI</u>** The first therapy session between Dr. Murgatroyd and Lionel Desmond is held. An initial intake assessment is completed. The following highlights from the session include: *1. "He expressed his concerns about transitioning to civilian life, and is worried about "not fitting into society". He continues to feel like a member of the military."* *2. "Client talked about some of his experiences in Afghanistan and, at times, was difficult to redirect, jumping from one event to the other. He said on a few occasions he fell on his head and that this was never properly assessed for possible brain damage."* *3. "In terms of PTSD-like symptoms, Mr. Desmond reported often having night sweats, which disrupts his sleep. He also reported experiencing daily intrusive thoughts about his combat experience. He says he is often "on guard" when he finds himself in social situations."*	Exhibit P-000244 [page 80]

	4. *"His mood was described as being "down". He said his energy levels are low. He described having lost interest in doing normal activities ..."* 5. *"His mood appeared dysthymic. Mr. Desmond did not report any SI/HI."* 6. *"Client reports having few supports in the community, as his family and wife are living in and around Antigonish, NS. He said his wife and daughter have lived there approximately six years."* 7. *"He describes having a tense relationship with his father-in-law."* 8. *"Other than his use of alcohol, he said that another coping strategy of his is to keep busy with projects such as doing mechanical repair work on his car."*	
June 25, 2015	Lionel Desmond attends the Veterans Affairs Canada (VAC) office located at the Canadian Armed Forces (CAF) base in Gagetown and provides Veterans Affairs Canada (VAC) with a completed application for rehabilitation services. His actions are suggestive of a strong motivation on his part to begin rehabilitation and reintegration as a civilian.	Exhibit P-000273 [page 19]
June 26, 2015	Lionel Desmond is formally released from the Canadian Armed Forces (CAF).	Exhibit P-000273 [page 19] Exhibit P-000244 [page 81]
July 2, 2015	Lionel Desmond attends his first appointment with Dr. Paul Smith. Dr. Smith is a family physician who has been in practice for over 40 years in the Fredericton, New Brunswick, area. Dr. Smith began treating many patients who were in the military, either presently in	Transcript February 24, 2020 [pages 26 - 27]

	active service, retired service, or military veterans. Dr. Smith began prescribing medical marijuana for pain as early as 2004 or 2005. In 2014 he began to use medical marijuana more extensively in treating his patients. On July 2, 2015, Lionel Desmond met with Dr. Smith for approximately one (1) hour and completed a medical assessment form. Dr. Smith also received a medical assessment form completed by Dr. Vinod Joshi dated September 28, 2011. Dr. Smith was aware that Lionel Desmond had been discharged from the military on June 26, 2015, and that he had previously served in Afghanistan. Lionel Desmond presented with a diagnosis of Post-Traumatic Stress Disorder and was suffering from pain and insomnia. He also had a diagnosis of Major Depressive Disorder. Lionel Desmond described his symptoms as including high levels of hypervigilance, depression, flashbacks and intrusive memories, and anger and irritability. Dr. Smith learned that Lionel Desmond was married and that his wife Shanna Desmond was a registered nurse. He felt that Lionel Desmond and his wife were struggling in their marriage and that money was an issue. Lionel Desmond was on a number of prescriptions at that time including Zopiclone, Risperidone, Effexor and Viagra. Lionel Desmond described having significant lower back pain in his spine from his mid-thoracic down to the lumbar. Dr. Smith felt it was appropriate to prescribe medical marijuana to treat Lionel Desmond's symptoms and wrote prescriptions for cannabis from two (2) sources totalling ten (10) grams per day. This was to be part of a trial to determine its effectiveness in treating his symptoms. The prescription was for four (4) months. Dr. Smith made a follow-up appointment with Lionel Desmond for October 1, 2015.	Transcript February 24, 2020 [pages 89 - 90]
July 3, 2015	**<u>Therapy Session #2 New Brunswick OSI</u>** The second therapy session between Dr. Murgatroyd and Lionel Desmond takes place on this date. Highlights from this session include: *1. "Intrusive thoughts, disturbed sleep (including night sweats), paranoia and homicidal thoughts (without intent) all occur on daily basis. He does not report any suicidal thoughts. He*	Exhibit P-000244 [page 79]

	said his mind is constantly racing, and that he generally feels like a "robot"" 2. *"On top of that, he continues to report significant personal stressors, including trying to sell his house, re-connecting with his wife and daughter (who are living in Nova Scotia), and dealing with VAC and multiple health professionals. He reports having no social supports in the community. He said he hardly gets out of the house because of his paranoia."* 3. *"His primary coping method is that of abusing alcohol. He said he is currently drinking approximately 6 beers per day."*	
	Dr. Murgatroyd expresses that due to Lionel Desmond's difficulty in remaining focused and his level of distress they are unable to begin psychoeducation or trauma treatment. Dr. Murgatroyd notes: *"Writer intended on giving psychoeducation relating to the stress response and breathing techniques, but Mr. Desmond was again difficult to redirect and writer did not have enough time during the session."* Dr. Murgatroyd also noted: *"Today we talked further about the possibility of doing trauma work. However, Mr. Desmond was visibly distressed by the thought of doing trauma work at this time. He became distant, and did not speak for several minutes during the session."*	Exhibit P-000244 [page 79]
July 9, 2015	**Missed New Brunswick OSI Appointment #2** Lionel Desmond advises Dr. Murgatroyd that he will be missing his July 10, 2015, appointment. He states that he will be returning to Nova Scotia for approximately one (1) month and he will be staying at his mother's residence. He states, "all of his family and supports" are in Nova Scotia and he "hopes to reconnect with his wife and daughter." Mr. Desmond is offered a phone session but states he will contact Dr. Murgatroyd if needed.	Exhibit P-000244 [page 78]
August 13, 2015	Lionel Desmond attends at the Guysborough Memorial Hospital and is treated by Dr. Ranjini Mahendrarajah for a bee sting. This is the first time Dr. Mahendrarajah recalls meeting Lionel Desmond.	

	<u>Continuity of Care Gap #2: Approximately 2 months (July 3, 2015, to August 31, 2015)</u> Mr. Desmond stays in Nova Scotia much longer than his initial plan of one (1) month. During that time, he also misses several critical appointments with New Brunswick OSI Psychiatrist Dr. Anthony Njoku. This will be the only contact Lionel Desmond has with anyone from the New Brunswick OSI Clinic in approximately two (2) months. There has been no mental health treatment or assessment since July 3, 2015, until the introductory August 31, 2015, assessment with Dr. Njoku.	Exhibit P-000244 [pages 76 – 78]
August 31, 2015	**<u>Psychiatry Appointment #1 New Brunswick OSI Dr. Njoku</u>** Lionel Desmond meets with and is assessed by Psychiatrist Dr. Njoku for the first time. At the forefront of the observations is Mr. Desmond's heightened paranoia, frustration, and anger towards Shanna Desmond. Reflecting on this Dr. Njoku makes the following remarks: 1. *"Overall, he was presenting today with multiple stressors from family as his wife and family had re-located to Antigonish."* 2. *"His relationship was quite significantly impacted and he went on at great lengths complaining about his wife, her family, his distrust of them and multiple incidents triggered by his anger that had contributed to a major strain in his relationships with them."* 3. *"He, nevertheless, admits there are strong relationship problems not only between himself and his wife but also with his wife's family."* Other notable highlights from this initial psychiatric assessment include: 1. *"… on review today he, himself, was really very agitated, very distractible, and difficult to get a coherent linear account of things from him."*	Exhibit P-000244 [pages 33 - 35]

2. *"He reports very increased flashbacks, he'd apparently stayed for a brief while in Halifax and found intermingling with the multicultural society there where he often came across Arabs, triggered a worsening of his flashbacks. Other triggers included certain smells of food and together they had caused a heightening of homicidal thoughts towards Arab people within him."*

3. *"His sleep had worsened, he was waking up most nights sweating and felt extreme anger and rage throughout the day. He was very irritable, he struggled to tolerate being around others and as result, was quite very isolated and cut off, very jumpy and quite distressed from his daily reliving experiences which preoccupied him. Even while talking to me, he was quite frequently preoccupied with random details of his traumatic experiences and admitted he was beginning to feel quite paranoid and unsafe in himself."*

4. *"… currently was still taking at least twelve beers daily."*

Lionel Desmond is also noted as having a history of being "slow to open up" with mental health professionals. As well, he expresses concerns that he may not be able to "maintain any consistency" with New Brunswick OSI treatment given his plans to return to Antigonish, Nova Scotia.

After completing a mental state examination Dr. Njoku reported the following:

"… I saw a very agitated distractible gentleman who was very difficult to keep on task in terms of giving me a linear account of his troubles. He was quite very circumstantial and often preoccupied with re-telling multiple trauma accounts irrespective of the line of questioning put to him. On account of his agitation, he used a lot of swear words, he made verbal threats against un~~armed~~named others but was difficult to establish any strong intent behind any of the threats uttered. He was clearly very irritable but I didn't see evidence to suggest suicidality or any underlying psychosis. There were a few dissociative episodes though whilst here particularly during moments of re-telling his trauma accounts. His insight was only moderate and I don't think he completely appreciated the severity of his symptoms and the requirement to have more consistent treatment although he states he has been largely compliant with his medications."

	In terms of formulating his initial impression, Dr. Njoku finds that Lionel Desmond is *"… still very severely suffering from his PTSD symptoms which don't really seem to have relieved much or perhaps has further exacerbated following release."* In terms of assessing suicidal and homicidal risk, Dr. Njoku notes the following: "*He did make homicidal threats but it appears from his previous notes this on and off has been a feature with him without any evidence he'd ever acted on it. He, however, wasn't suicidal and has no previous history of suicidal acts either. His mood appeared depressed and he was very anxious today."* Notably, Dr. Njoku at this first appointment expresses concerns over ensuring continuity of care given Lionel Desmond's transient circumstances. "*There are some further complications considering he was planning to return to Antigonish which might make it difficult to offer him regular outpatient follow up and monitoring although he did say he was open to receiving treatment from Halifax if possible*." No immediate adjustments are made to Lionel Desmond's medications. He continues to be prescribed Effexor XR 150 mgs qds, Risperidone 2 mg qhs, Zopiclone 10 mg qhs, Ativan 1 mg. Dr. Njoku notes that medical marijuana "may actually be further exacerbating his agitation and worsening symptoms." Dr. Njoku concludes with the overall impression that Lionel Desmond is "at significant risk and is clearly quite ill at the moment."	
August 31, 2015	It is now over two (2) months since Lionel Desmond's military release and his completed application for veterans rehabilitation services and programming. Little, if anything, appears to be done on his file. As a result, Lionel Desmond calls the Veterans Affairs Canada (VAC) office. He is eager to be assigned a Veterans Affairs Canada (VAC) case manager who can begin assisting him with his rehabilitation and transition. The internal system entry heading is	Exhibit P-000273 [page 18]

	recorded in caps: **“**REQUEST FOR CASE MANAGEMENT – URGENT.” The system entry reads: *a. “Client stated he was advised he would get a CM a few months ago and still waiting. Feels he has the need to be Case Managed.”* b. *“Tried to warm transfer to get a CM on the line for client, but kept getting voice mail. So explained to him I would send urgent work item and if he does not hear from someone from local AO by the end of the week to call back. Client stated he would.”* Despite what he was told, Lionel Desmond never did hear back from Veterans Affairs Canada (VAC). Over the next few months, he will continue to contact them on his own initiative. He will continue to express the importance and urgency of being assigned a case manager. During the Inquiry, Marie-Paule Doucette was asked if she could offer an explanation regarding these wait times and she testified: *“When I first arrived, this is a specific example of it took several months before he was assigned. And, again, that’s beyond me and anything that I was able to do, but my understanding is that, you know, a few years prior. And this is just my personal understanding, and I may not be getting the facts exactly, but I believe it was around 2012, there were some significant cuts made, under the Conservative government, in Veterans Affairs. … And so when I arrived in 2015, I was part of that first cohort of sort of massive recruiting of case managers across the country. So there was a clear shortage of resources at that time.”* Prior to the above phone call on this date, Lionel Desmond also attended in person at the Veterans Affairs Canada (VAC) office located on the Canadian Armed Forces (CAF) base in Gagetown. Earlier in the day, he had been requesting information regarding the status of his disability claim and clarification regarding letters he had received.	Transcript June 23, 2021 [pages 89 – 90]
September 29, 2015	**<u>Missed New Brunswick OSI Appointment #3 Psychiatrist Dr. Njoku</u>** Without explanation Lionel Desmond does not show up for his second psychiatry appointment with the New Brunswick OSI.	

October 1, 2015	Lionel Desmond met with Dr. Smith for approximately one (1) hour. Dr. Smith made note of Lionel Desmond's symptoms and indicated that there was significant improvement in his symptoms. Lionel Desmond had been consuming cannabis with the use of a vaporizer.	
October 2, 2015	It has now been over three (3) months since Lionel Desmond's military discharge. Despite his early request to be assigned a Veterans Affairs Canada (VAC) case manager this has not happened. The evidence suggests that Veterans Affairs Canada (VAC) made little to no effort in assigning a case manager or assessing Lionel Desmond's rehabilitative needs during this critical three (3) month period post military release. Concerned about the delay, Lionel Desmond contacts Veterans Affairs Canada (VAC) by phone. The system entry reads: *"CM follow-up from client who's anxious to hear from one asap at 506-261-9024 . Please see note 31 Aug note as well ."* Upon reviewing this specific system entry at the Inquiry, Ms. Doucette testified: *". . . Like it's documented that he's awaiting assignment and I think it's safe to assume that he wasn't the only person in that situation given the shortage of resources."*	Exhibit P-000273 [page 18] Transcript June 23, 2021 [pages 91 – 92]
October 14, 2015	Lionel Desmond again contacts Veterans Affairs Canada (VAC). He is checking on the status of his request for a case manager. He is described as being anxious. The following internal system entry is made: *"CM – Client following up on status of CM assignment. No new info. … Client still awaiting CM assignment; is anxious to be assigned so he can speak with him/her. Please ensure progress for CM assignment is still ongoing."* During the Inquiry Ms. Doucette was further asked if she could elaborate on what appears to be an extended delay. She testified:	Exhibit P-000273 [page 18] Transcript

	"The best guess that I can give you is we just don't have the resources to meet the demand that's coming in. So, again, I think it's safe to assume that Lionel Desmond was probably among a group of veterans awaiting assignment and then I'm not sure exactly how they're prioritized. Typically, by date of admission per eligibility for their program, but there may be exceptions where someone is deemed an extremely high risk. I don't know. That wasn't my role." Despite what actually occurred, Ms. Doucette testified that it was in Lionel Desmond's best interest to be assigned a case manager in a timely manner. *"Well, I think everybody, it's in everybody's interest to be assigned in a timely manner, for sure, and that he is no exception to that."*	June 23, 2021 [page 92] Transcript June 23, 2021 [page 93]
October 22, 2015	After not having heard from Lionel Desmond in over three (3) months (July 9, 2015) Dr. Murgatroyd attempts to contact him by phone. The following note is made: "*Dr. Njoku expressed concerns following Mr. Desmond's missed appointment with him on September 29th 2015. We are trying to see how he is doing and clarify what his current living arrangement is, whether he is still living in Oromocto or if he has moved permanently to Antigonish, NS. Dr. Njoku intends to transfer his file over to the OSI Clinic in Halifax, for psychiatric follow-up, if he decides to move to Antigonish.*"	Exhibit P-000244 [page 77]
October 23, 2015	**<u>Continuity of Care Gap #3: Approximately 2 months (August 31, 2015, to October 23, 2015)</u>** Dr. Murgatroyd initiates a phone call to Lionel Desmond. As a result, this is the first time Mr. Desmond has communication with the New Brunswick OSI Clinic since his August 31, 2015, appointment with Dr. Njoku. There has been no mental health treatment or assessment since August 31, 2015. Mr. Desmond has been living in Antigonish, but his accommodations are very much in flux. He is staying between "his wife's parents' place or his mom's place." His New Brunswick house is still for sale and he only returns to that province "about once a month."	Exhibit P-000244 [page 76]

	Dr. Murgatroyd questions why Lionel Desmond cancelled his upcoming September 29th appointment with Psychiatrist Dr. Njoku. The following note is made: *"He said he cancelled because he was worried he'd be forced to go to Montreal for treatment, which had been discussed as a treatment option. At this time, he said he needs to be with his family (wife and daughter). He reported that things remain "up and down"."*	
	Since the initial New Brunswick OSI referral on May 1, 2015, Lionel Desmond has received very little mental health intervention over the five (5) month period. The extent of his interactions with the New Brunswick OSI Clinic have been limited to the initial intake assessment, two (2) therapy sessions, an initial psychiatric assessment, and two (2) phone calls. Dr. Murgatroyd appears to recognize this as being a concern and notes the following: *"In terms of follow-up treatment, Mr. Desmond said he'd be open to travelling to Halifax since it's a shorter distance. I told him that we would be transferring his file over to the OSI Clinic in Halifax. I told him he could expect a call from the Halifax clinic in the coming weeks."*	Exhibit P-000244 [page 76]
November 5, 2015	A Veterans Affairs Canada (VAC) internal data entry is made on this date. This entry confirms that as late as four and a half (4 ½) months after Lionel Desmond's military release he is yet to be assigned a Veterans Affairs Canada (VAC) case manager. The system entry states: *"File review as per CSTM, WIs sent to CSTM as he's awaiting assignment to a CM."*	Exhibit P-000273 [page 17]
November 9, 2015	An additional two (2) weeks have passed since Lionel Desmond last had contact with the New Brunswick OSI Clinic. The total sum of actual treatment over a six (6) month period involves two (2) introductory therapy sessions with Dr. Murgatroyd. On this date Lionel Desmond contacts Dr. Murgatroyd by phone. He is described as in a state of "distress" and "really upset" with his wife and her parents. He is having disagreements with Shanna Desmond over finances and her plan to visit her sister in Regina over	Exhibit P-000244 [page 75]

	the holidays. He has concerns over the cost and that she excluded him by only purchasing tickets for herself and their daughter. He is "in the process of separating their accounts." He reports that she and her parents were "unsupportive" about his mental health. Most significantly, he "admitted to having fleeting homicidal thoughts but no intent. He said he would not hurt anyone."	
	OSI Intake Nurse Christine Lillington speaks with Dr. Murgatroyd. The following notes are made: 1. "*He* [Dr. Murgatroyd] *stated that client is not doing well*." 2. "*Mathieu stated that client was having trouble paying for prescriptions because of health insurance not kicked in yet*? [*sic*]" 3. "*Mathieu stated client does not have a VAC CM as well*."	Exhibit P-000244 [page 24]
	Dr. Murgatroyd makes the following additional observations: *"Due to the lack of support, he said he is no longer staying with his wife at her parent's place. He said he is staying at his wife's aunt's place who, according to Mr. Desmond, is more supportive. He said he has no medication at this time. He indicated he has been without medication for about a month. However, he does have some medicinal marijuana, which he said helps to calm him down."*	Exhibit P-000244 [page 75]
	According to Dr. Murgatroyd's November 9, 2015, progress note, Lionel Desmond has been waiting to hear back from the Nova Scotia OSI Clinic and received a phone message from them: "*Writer asked him whether he was contacted by the Halifax OSI Clinic. He said he had gotten a phone message, but that the message erased itself before he could follow-up on it."* "*Writer told him that writer would contact the OSI Clinic in Halifax to inform them about his situation*." Directly following this appointment Dr. Murgatroyd speaks to a New Brunswick OSI nurse by the name of Christine Lillington. The following progress note is made:	Exhibit P-000244 [page 75]

	"Writer contacted Christine Lillington, nurse at the OSI Clinic in Halifax. Ms. Lillington said she had attempted to contact Mr. Desmond in late October/early November without success. He had not returned her call. At the time of this call, she said she had actually tried to reach him again while writer was talking to Mr. Desmond. Ms. Lillington said she would try to contact him again in the afternoon to set up an appointment with her next week."	
November 13, 2015	**Therapy Session #3 New Brunswick OSI** Session with Dr. Murgatroyd. During this session Mr. Desmond continues to be upset with Shanna Desmond and their finances. He advises that he is "working on changing his bank account, so that his wife does not have access to his money." He clarifies that a Regina plane ticket was in fact bought for him, however, he remained upset that she did not discuss the plans with him. In addition, Mr. Desmond expressed "that he is the one paying for his wife's tuition fees and car." He is now thinking about getting a divorce and is actively looking for a lawyer. He expressed frustration of Shanna Desmond's unwillingness to transfer to the University of New Brunswick. Mr. Desmond expresses resentment towards Shanna Desmond's parents. He feels they talk bad about him to her because of his PTSD diagnosis. Dr. Murgatroyd makes the following notation regarding suicide and violence: *"Mr. Desmond did not express having any suicidal thoughts. And while he has had violent thoughts, they are usually fleeting thoughts related to his experiences in Afghanistan. He does not report any homicidal intent. Mr. Desmond said he is no longer drinking alcohol."*	Exhibit P-000244 [page 74]
	Dr. Murgatroyd again makes note of the fact that Lionel Desmond's current residency is in Nova Scotia. Given the living situation, Dr. Murgatroyd again expresses that he will contact the New Brunswick OSI satellite office in Nova Scotia: *"Since Mr. Desmond will be staying mostly in Antigonish, NS, for the next while, writer and Mr. Desmond planned to set him up with the OSI Clinic in Halifax. Writer gave him the number to contact*	Exhibit P-000244 [page 74]

	Christine Lillington, OSI nurse, to set up an appointment with her. He agreed to this plan and was going to get in touch with her early next week. In the meantime, we will also try to find him a therapist, closer to him, in the community."	
November 18, 2015	Lionel Desmond calls the St. Martha's Hospital crisis line at 10:00 a.m. and 1:00 p.m. and speaks with a crisis clinician. Records destroyed after 6 months if person does not attend.	
November 18, 2015	RCMP Investigation File # 20151494158 At 12:20 p.m. Shanna Desmond called NS Guysborough RCMP requesting a wellness check on Lionel Desmond who was in a manic state. Lionel Desmond left the military in June/July 2015. He had been suffering from PTSD and depression. A crisis worker at St. Martha's Regional Hospital recommended that Desmond be brought in. Shanna stated, "harm may come, not sure to him or someone else." Shanna Desmond also advised Lionel Desmond had access to and was prescribed medical marijuana. At 4:40 p.m. Shanna Desmond again phoned NS Guysborough RCMP. This time she advised that Lionel Desmond had attended his Aunt Sarah MacEachern's residence located at 15371 Hwy 16, Upper Big Tracadie. Shanna Desmond was looking for the RCMP to come and speak with him. At 5:00 p.m. Sgt. Addie Maccallum attended Sarah MacEachern's residence and spoke to Lionel Desmond, his aunt and Shanna Desmond. Shanna Desmond advised that Lionel Desmond was not threatening to hurt himself or others but has done so in the past. She also advised that Lionel Desmond had stopped taking his medications and it's unknown if he had been seeking medical attention for his PTSD. She further reiterated that Lionel Desmond was "manic several times today." Sgt. Maccallum described Desmond as "calm & lucid." Lionel Desmond advised that he came to Guysborough to see his estranged wife and daughter who were staying next door and to do some hunting. Desmond "stated he does get manic episodes, including today due to his mental health but knows how to handle them by avoiding conflict." Lionel Desmond admitted to having stopped certain medications after consulting two (2) doctors (Dr. Paul Smith & Dr. Matthews). He had follow-up appointments in New Brunswick next week.	Exhibit P-000033 Exhibit P-000034 Exhibit P-000032

		Lionel Desmond advised that he will call if deteriorating or in need of assistance. Shanna was updated and "very glad to hear Desmond has a plan in place for followup [*sic*] treatment & would be supportive of him when back in NB." A Firearms Interest to Police ("FIP") was created as a result of this occurrence. Exactly when it was created is unclear. It does not appear as though the Chief Firearms Officer of Nova Scotia was ever engaged. Furthermore, it does not appear as though the Chief Firearms Officer of Nova Scotia ever conducted an independent licence review/investigation as a result of this incident. Lionel Desmond's licence was not placed under review at that time or at any point by the office of the Nova Scotia Chief Firearms Officer.	
Nov. 19,	**2015**	Dr. Murgatroyd decides to remain as Lionel Desmond's therapist. The New Brunswick OSI team felt this was best "given that the alliance has already been established." This decision was made despite recent documented concerns. The New Brunswick OSI had been very concerned about Lionel Desmond's unsettled living arrangements, lack of contact, and missed appointments. Up to this date, there had also been considerable push to have Lionel Desmond connected with the Nova Scotia OSI Clinic and other Nova Scotia resources which would be closer to his community. Moving forward the plan is now to "meet with Mr. Desmond whenever he is in New Brunswick, and schedule sessions over the phone whenever he is in Antigonish." Dr. Murgatroyd contacts "newly assigned" Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette. She is updated on "recent events" and plans to contact Mr. Desmond "in the near future." The following entry is made by Dr. Murgatroyd with respect to accessing resources in Nova Scotia. "*We also talked about the possibility of his booking a follow-up appointment with Dr. Njoku, rather than connecting with the OSI Clinic in Halifax, especially if he decides to remain in New Brunswick.*"	Exhibit P-000244 [pages 73 and 99]

November 19, 2015	Lionel Desmond is finally assigned a Veteran Affairs Canada (VAC) case manager. The case manager is Marie-Paule Doucette. However, Lionel Desmond has yet to meet with her. New Brunswick OSI Psychologist Dr. Mathieu Murgatroyd calls Ms. Doucette to express concerns regarding Lionel Desmond's "instability" and advises that he is in need of "coordinated support." Dr. Murgatroyd explains that he has built a rapport with Lionel Desmond and that "he is willing to do therapeutic work with him for PTSD once he is in a more stable place." Ms. Doucette makes the following system entry: "*Writer obtained Dr.'s opinion re: immediate risks and needs.*" On this date, Ms. Doucette also made a system entry stating:	Exhibit P-000273 [page 17]
	"Writer is in the process of familiarizing with file as the newly assigned Case Manager and will attempt to connect with client as soon as possible."	Exhibit P-000273 [page 17]
	Ms. Doucette is in a position to play a key role in coordinating Lionel Desmond's civilian rehabilitation and transitioning. However, she is privy to very little documentation/information from the Canadian Armed Forces (CAF). She has access to the May 25, 2015, Transition Interview document, a list of Lionel Desmond's disability awards/benefits, and an overview of the current services he is accessing with Veterans Affairs Canada (VAC). Finally, she is aware that Lionel Desmond was granted access to the Veterans Affairs Canada (VAC) rehabilitation program on the basis of his PTSD diagnosis. She has few documentary records beyond that. She does not have access to his extensive Canadian Armed Forces (CAF) medical mental health history or even a summary. She is unaware of what mental health interventions were put in place while he was treated by Canadian Armed Forces (CAF) Psychologist Dr. Wendy Rogers and Psychiatrist Dr. Vinod Joshi. She does not know what treatments were effective and those which were ineffective. At the Inquiry, Ms. Doucette acknowledged such information could have been of value to contract service providers retained by Veterans Affairs Canada (VAC).	Transcript June 23, 2021 [pages 94 – 98]
	"That would be, in my perspective, information that would be way more valuable to the current treating health professional as opposed to a person who is coordinating. So if he's working with Dr. Njoku,	Transcript June 23, 2021 [page 97]

	at the time, for example, the psychiatrist, and Dr. Murgatroyd, the psychologist, and they may benefit from way more than me from having access to prior treatment info." There is no evidence to suggest that Canadian Armed Forces (CAF) shared or sought Lionel Desmond's consent to share his military medical file with any outside service provider including the Operational Stress Injury Clinics in New Brunswick and Quebec. Nor is there evidence to suggest that these valuable records were ever shared with provincial health care providers. Perhaps most significantly, Lionel Desmond does not appear to have ever been provided with a copy of his Canadian Armed Forces (CAF) medical file.	
November 20, 2015	Lionel Desmond calls the St. Martha's Hospital crisis line at 3:30 p.m. and speaks with a crisis clinician.	
November 20, 2015	Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette attempts to contact Lionel Desmond for the first time. He does not answer and she leaves an introductory voice mail.	Exhibit P-000273 [page 17]
November 25, 2015	Dr. Murgatroyd contacts Mr. Desmond by phone. Lionel Desmond is noted as appearing "to be in distress, but said he was at the Marijuana for Trauma Clinic to help relieve some of the distress." Mr. Desmond confirms that he continues to have "disputes with his wife and her parents." He wants to contact social development/child aid. Given the inability to offer therapy, Dr. Murgatroyd offers "supportive listening." "Coping strategies" will be addressed at the next session.	Exhibit P-000244 [page 72]
November 26, 2015	Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette makes a second attempt to connect with Lionel Desmond via phone. She is notified by way of an automatic message that Lionel Desmond is unable to receive incoming calls on his cell phone. She does not have an alternate phone number on file and therefore reaches out to New Brunswick OSI Psychologist Dr. Mathieu Murgatroyd. The system entry reads: *"Writer proceeded to call Dr. Murgatroyd at OSI clinic who had initiated a conversation regarding client last week. VM message left with psychologist to advise of inability to connect with client. Writer*	Exhibit P-000273 [page 16]

	asked that psychologist, who was to see client tomorrow, encourage him to connect with CM as soon as possible."	
November 27, 2015	Five (5) months after his military release, the first contact occurs between Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette and Lionel Desmond. Ms. Doucette testified that she recalls little of this first introductory phone call other than to say that it was agreed that she would schedule a time for them to meet in person. The in-person meeting would be the start of the rehabilitation assessment process. A case plan/rehabilitation plan has yet to be opened.	Exhibit P-000273 [page 16]
	A case plan is a tool/document where the case manager works with the veteran to identify barriers, goals, authorized services, identify resources, and monitor progress. By nature, there is no prescribed expiry date to a rehabilitation program as it continues to evolve depending on the veteran's progress, ongoing needs, and challenges.	Exhibit P-000292 [pages 8 – 10]
	During the very first contact with Ms. Doucette, Lionel Desmond advises her of his current and long-standing struggles with mental health and the instability within his marriage. The concerns he expresses during this first conversation are to such a degree that it prompts Ms. Doucette to ask him if he is thinking of suicide or self-harm. The client screening note from this day reads:	
	a. *"Client returned writer's call and expressed being pleased to have finally been assigned a CM."*	Exhibit P-000292 [page 9]
	b. "Without being probed, client spoke at length of his family situation which he describes as difficult at the moment. His intimate relationship is unstable and he has been back and forth between his home in Oromocto and his wife's family home in NS. Client and his wife have an eight year-old daughter."	
	c. *"Client said he saw OSI clinic psychologist in Fredericton today and plans to see him again next week. Client released from the military in the summer and is struggling to cope with mental health symptoms. He assured he is not thinking of suicide or self-harm. Writer described VAC Assistance Service and client took note of number. He was encouraged to keep it handy and to use it if/when he finds he needs to talk and cannot access his positive supports."*	

	Ms. Doucette confirmed that Lionel Desmond was someone who very early on wanted to engage professional help: *"So, yeah, the sort of snapshot that I got was someone who was somewhat isolated and was wanting to feel better. Like he talked about his emotional difficulties and very much wanted to engage with professional help."* During the Inquiry, Ms. Doucette was asked a series of questions around the fact that Lionel Desmond is of African Nova Scotia descent. In particular, the questions related to how that might have factored into developing the rehabilitation case plan. Ms. Doucette testified that as a Veterans Affairs Canada (VAC) case manager she had not received any training as it relates to unique struggles or barriers facing military veterans of African Canadian descent. Ms. Doucette testified: *"… I recognize that we are in 2021 now and there's been huge jumps in terms of awareness around anti-Black racism and I'm not saying that the issues didn't exist in 2015. I just appreciate that the question in today's context has significant value. So to answer your question about cultural awareness training, I didn't have any offered at VAC. I did have some through my Masters studies, but I don't think race is something that we spent much time on in my work with Mr. Desmond."*	Transcript June 22, 2021 [page 93] Transcript June 23, 2021 [pages 158 – 159]
November 27, 2015	**<u>Therapy session #4 New Brunswick OSI</u>** Lionel Desmond discusses his perceived lack of supports in Antigonish, Nova Scotia. He would now like to relocate to New Brunswick as "Antigonish is too stressful at this time." Dr. Murgatroyd notes that some of Lionel Desmond's "basic needs" do not appear to be met, such as proper nutrition. It is noted that "The focus of therapy will remain on stabilization."	Exhibit P-000244 [page 71]
November 27, 2015 **10:22 p.m.**	RCMP Investigation File # 20151535440 Lionel Desmond is residing in Oromocto, New Brunswick.	Exhibit P-000084 Exhibit P-000083 CAN001840

	On November 27, 2015, Shanna Desmond called the New Brunswick RCMP from her residence in Nova Scotia reporting that she was receiving concerning text messages from Lionel Desmond. She reported he is very depressed and made comments to her about committing suicide. Desmond wanted Shanna to "tell his daughter he will see her in heaven," that "it was time to go," "he will be "resting in peace"," and "going into the garage now" where he kept his firearm. Cst. Steven Richard and other New Brunswick RCMP members immediately attended Lionel Desmond's residence in Oromocto. Desmond indicated that he was depressed and had PTSD. He agreed to attend the hospital to seek medical assistance. RCMP officers stayed with Desmond until he was assessed by a doctor and released. Desmond was assessed by Dr. Ginn at 1:10 a.m. Upon his hospital release at 1:30 a.m. he was provided with a mobile crisis business card. RCMP transported Desmond back to his residence. A .223 rifle (SN # H8142629) was seized from the garage at Lionel Desmond's New Brunswick residence. Cst. Richard instructed Cpl. Arbour of New Brunswick RCMP to contact Shanna Desmond and advise her to gather up any Nova Scotia firearms owned by Desmond. This occurrence generated a Firearms Interest to Police ("FIP") notification to the Chief Firearms Officer of New Brunswick, Derek Eardley. As a result of this occurrence Desmond's licence was placed under review by New Brunswick Chief Firearms Officer December 29, 2015. New Brunswick Firearms Officer Joe Roper was assigned to review/investigate licence.	Exhibit P-000132
November 28, 2015 **Two (2) RCMP Calls**	RCMP Investigation File #'s 20151539202 & 20151539308 On November 28, 2015, Cst. Len MacDonald received a call from an "elevated and upset" Lionel Desmond. Desmond advised that he just returned from Oromocto, New Brunswick to Nova Scotia. He was looking to retrieve some of his belongings. Desmond had just learned that his wife had taken his .308 Savage rifle (SN # H078347) and other items from his car which were located at his aunt's house.	CAN001745 Exhibit P-000087 Exhibit P-000088 Exhibit P-000132

	Cst. MacDonald noted in his report:	
	"Cst MacDonald was aware of Lionel Desmond only by name as Cpl O'Blenis and Sgt MacCallum had been involved with him during an occurence [*sic*] *a week prior. Cst MacDonald knew Lionel Desmond to be suffering from a stress injury after his last tour in Afganistan* [*sic*] *and was working with military health care proffessionals* [*sic*] *at CFB Gagetown to treat the injury."*	Exhibit P-000087 [page 3]
	"Shanna Desmond advised that [yesterday] the Oromoncto [*sic*] *RCMP located Lionel Desmond and detained him under Provincial mental health legislation to ensure his safety and as a result of his detention a firearm in his Ormoncto* [*sic*] *home was siezed* [*sic*] *for safekeeping."* (.223 rifle SN# H8142629)	
	"… Shanna Desmond spoke at lenght [*sic*] *about the events that led to the occurence* [*sic*] *and she advised that she contacted the Ormoncto* [*sic*] *RCMP the day prior afher* [*sic*] *getting texts from Lionel Desmond suggesting he may have suicidal thoughts and might harm himself."*	
	"Shanna Desmond also advised that Cpl Arbour of the Ormoncto [*sic*] *RCMP had asked her to secure Lionel Desmond's only other firearm from his aunts* [*sic*] *home in Upper Big Tracadie until Lionel Desmond's mental well being could be assured. Shanna Desmond told Cst MacDonald she took the firearm from the home at 15371 16 Highway Upper Big Tracadie, NS and left it with her friend Thomas Gero ..."*	
	Shanna Desmond requested information about the peace bond process. Cst. MacDonald provided her with a Victim Services referral card. Shanna would not agree to accept the referral to Lori Castle of Naomi Society. However, she did take the card and indicated she would contact the Naomi Society on her own time.	
	On November 28, 2015, there was a second simultaneous call made to the RCMP (RCMP Investigation File # 20151539308). Richard Borden called to advise that:	
	"… the estranged spouse of his daughter, Lionel Desmond is on the neighboring property yelling at his home. Borden advises Desmond trying to locate a firearm his daughter secured at the request of Ormoncto [*sic*] *RCMP after Desmond was involved in an occurence* [*sic*] *related to his mental health."*	Exhibit P-000088 [page 1]

	Cst. MacDonald attended. Towards the end of RCMP interaction, Desmond is described as "calm and cooperative. Desmond agreed to leave area and not reattend." *"Cst MacDonald explained to Lionel Desmond that the firearm would be secured at the Guysborough RCMP detachment and returned in conjunction with Cst MacDonald's investigation and that of the Ormoncto* [*sic*] *RCMP ..."* Cst. MacDonald reported: *"• secure firearm at Guysborough detachment* *• ensure firearm listed to detachment PAIN* *•liase* [*sic*] *with Lloyd Carter on proper disposition of firearm.* *• liase* [*sic*] *with Ormoncto* [*sic*] *RCMP to determine their concerns for return of the firearm in Guysborough RCMP care."* Neither of these two (2) RCMP occurrences in Nova Scotia generated a Firearms Interest Police (FIP) entry/designation. These remained unknown to both the Chief Firearms Officer in New Brunswick and Nova Scotia. Again, there is no suggestion that the Chief Firearms Officer of Nova Scotia was ever engaged.	Exhibit P-000087 [page 4]
November 29, 2015	Lionel Desmond's Nova Scotia firearm .308 Savage rifle SN # H078347 is seized by Cst. Len MacDonald at the residence of Thomas Gero, South River, Nova Scotia. Cst. MacDonald noted that he planned to secure the firearm at the Guysborough Detachment and liaise with Oromocto RCMP to determine their concerns for return of the firearm. Cst. MacDonald also reported: *"• liase* [*sic*] *with Lloyd Carter on proper disposition of firearm.* *• liase* [*sic*] *with Ormoncto* [*sic*] *RCMP to determine their concerns for return of the firearm in Guysborough RCMP care."*	CAN001744 Exhibit P-000087 [page 4]
November 30, 2015	Lionel Desmond contacts Dr. Murgatroyd to advise him that he was admitted to the DECH (Psychiatry Unit) the previous Friday (November 23, 2015). Dr. Murgatroyd noted the following: *"He indicated that the police came to get him at his house in Oromocto, late Friday, after they got a telephone call from Mr.*	Exhibit P-000244 [page 70]

	Desmond's wife who was concerned about his well-being. She and Mr. Desmond had been talking on the phone earlier that night. He said that he had been working on his will at the time. Frustrated with his current situation (with his wife and her parents), he told her he was planning to leave everything to his daughter. Mr. Desmond said that his wife did not understand why he would not leave her anything. She was also worried about the fact that he was working on his will. According to Mr. Desmond, he ended the telephone call by saying "goodnight, goodbye", which he thinks may have worried his wife and led to her calling the police. He insisted that he did not verbalize suicidal ideation/intent to her over the phone. Shortly after, the police arrived. He said that they also seized a gun he had with him."	
	During this session Mr. Desmond also expressed that "he may need a more intensive program" given the recent "intensity of his PTSD symptoms (i.e., mind constantly racing) …" Lionel Desmond feels that medication has not been effective and denies present suicidal or homicidal thoughts. Dr. Murgatroyd recommended that Lionel Desmond contact his Veterans Affairs Canada (VAC) case manager. Consent is also given to allow Dr. Murgatroyd to contact Shanna Desmond.	Exhibit P-000244 [page 70]
December 1, 2015	The second contact between Lionel Desmond and newly assigned Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette occurs by phone. Lionel Desmond discloses to her that police attended his residence on Friday, November 27, 2015. He advises that Shanna Desmond had reported to Oromocto RCMP that he was suicidal on this date and they seized his firearms. The client screening note reads: a. *"Client disclosed police reported to his residence in Oromocto on Friday after his wife called with concerns about his safety. He said he was saying goodbye to her over the phone and she interpreted his words/tone as a sign he may be suicidal. Client stated he was not. Police nonetheless intervened and took possession of his firearm (he has for hunting)as a precaution. Client denies any current thoughts of self-harm or suicide. He however admits to multiple difficulties which appear to be related to his PTSD diagnosis and marital problems."*	Exhibit P-000292 [pages 5 – 6]

	b. *"Client confirmed he will be meeting with Psychiatrist and Psychologist at OSI clinic Thursday am. He mentionned* [*sic*] *there may be talk about hospitalization in Ste-Anne-de-Bellevue. He said he needs to get the help. He remains open to meeting writer on Thursday and will provide an update re: appointments with MH professionals."* c. *"Client confirmed he has Mobile Crisis and VAC Assistance numbers in case he finds himself in need of immediate assistance."* Despite these heavy disclosures within the first two (2) conversations, there is no further contact between Ms. Doucette and Lionel Desmond for over a month until January 5, 2016. At this point, there is still no case plan or rehabilitation plan. The Area Counsellor Client-Centred Assessment is yet to begin. Such an assessment is the foundation upon which a rehabilitation case plan is constructed.	
December 3, 2015	**<u>Therapy Session #5 New Brunswick OSI</u>** Lionel Desmond discusses with Dr. Murgatroyd the RCMP events of November 27, 2015. Dr. Murgatroyd notes: "*He talked briefly about the events of last Friday, when the police came to his house after his wife called in fearing he was potentially suicidal. Mr. Desmond indicated that he was not in fact admitted to the DECH, because it was deemed he was not suicidal and not a risk to himself. He said he was only there for about two hours. Mr. Desmond said he has been in touch with his case manager, and that she is supposed to meet with him tomorrow.*" Lionel Desmond again expressed his willingness and desire to participate in the residential treatment program offered at Ste. Anne's Hospital, Montreal, Quebec. His immediate plans are to go to Regina, Saskatchewan, with his wife and daughter for the Christmas holiday. Dr. Murgatroyd advises Mr. Desmond of the OSISS Peer Support Program. Lionel Desmond consents to allowing Dr. Murgatroyd to contact Mr. Glenn Park, OSISS Peer Support Coordinator, on his behalf.	Exhibit P-000244 [page 69]

	Lionel Desmond also signs a consent allowing New Brunswick OSI to contact and share information with Shanna Desmond.	
December 3, 2015	<u>**Psychiatry Appointment #2 New Brunswick OSI Dr. Njoku**</u> Dr. Njoku makes several key observations regarding Lionel Desmond's continuity of care, required interventions, marital discord, and his mental health fragility. 1. *"He has been very inconsistent in engagement, frequently moving …"* 2. *"Overall, his presentation continues to remain rather challenging, he is still very irritable, easily angry, he's been involved in frequent arguments with his wife and at this point, it's quite difficult to tell how much of this is purely their own relationship difficulties as against his hyper arousal from PTSD."* *3.* *"… he admits it's really difficult going grocery shopping and when he is out and about, he constantly feels he is being watched."* *4.* *"He is cut off from any social activities …"* 5. *"His anxiety is ever present …"* *6.* *"He is still very easily startled and is constantly on guard. He continues to express very strong belief that he was a victim of several incidents of racism while at work."* Lionel Desmond continues to be resistant to medication. Dr. Njoku expresses concerns about Lionel Desmond's consumption of medical marijuana. The following notes are made: 1. *"As far as his medications go, he no longer believes they are helpful, he is convinced they were increasing his suicidality and, indeed, I've completely stopped all medications from the last two months whilst he is only using medicinal marijuana."* *2.* *"At the moment, in spite of his level of distress and agitation, I still feel perhaps he could be experiencing worsening symptoms on account of the medicinal marijuana but which equally might be doing some good for him."*	Exhibit P-000244 [pages 31 – 32]

	A second mental state exam is completed. Dr. Njoku reports the following results: *"On mental state examination today, he was actually somewhat more subdued than I had known him the last time, although still fairly irritable, agitated still and quite preoccupied with his trauma experiences. He sounded depressed, he felt lonely but he insists he is not suicidal currently. He has at some points in the past expressed homicidal ideas but on further exploring that today it appears what he has been describing are the trauma experiences of dead, blown up torsos he regarded as homicide scenes."* **Continuity of Care Gap #4: Lack of a Clinical Case Manager** Dr. Njoku concludes by recognizing the importance of Lionel Desmond's need for a clinical case manager who "may offer him a bit more support and motivation to re-engage with some structure." It is worth noting that despite this recognition Lionel Desmond does not receive a clinical case manager until approximately one (1) year later.	
December 4, 2015	Cst. MacDonald updated Shanna Desmond on the status of the seized firearm. A message was left with Shanna's sister at her father's home. Cst. MacDonald noted he was waiting on direction from Oromocto RCMP. The RCMP report noted: "• *liase* [*sic*] *with Lloyd Carter on proper disposition of firearm.* • *liase* [*sic*] *with Ormoncto* [*sic*] *RCMP to determine their concerns for return of the firearm in Guysborough RCMP care*."	CAN001752 Exhibit P-000087 [page 5]
December 9, 2015	Cst. S. Richard with the New Brunswick RCMP reported: *"During next dayshift (Dec 14th), contact Canadian Firearm Center for feedback on process of returning Desmond's firearm."*	Exhibit P-000083 [page 5]
December 11, 2015	Lionel Desmond calls to cancel his scheduled appointment with Dr. Murgatroyd. The reason for cancelling is that he is currently in Antigonish. He reports that he is "doing better" and "continues to	Exhibit P-000244 [page 68]

	work on his relationship." He again expresses his desire to attend a more intensive treatment program.	
December 12, 2015	A 3825 request for disclosure is faxed to the Guysborough RCMP Detachment requesting particulars of the November 18, 2015, occurrence (RCMP # 20151494158).	Transcript February 19, 2020 [pages 173 – 176] Exhibit P-000133 [page 2]
December 14, 2015	**<u>Phone Contact New Brunswick OSI</u>** Lionel Desmond advises Dr. Murgatroyd that he remains in Antigonish. He continues to work on his relationship, and he plans to leave for Regina on December 17. Contact has yet to be made with Mr. Glenn Park, OSISS Director. Mr. Desmond states "getting better is his priority, and so he wants to go to treatment." He is willing to discontinue marijuana in order to enroll in the Ste. Anne's program.	Exhibit P-000244 [page 67]
Dec. 15, 2015	A recommendation is made for Lionel Desmond's admission to the Ste. Anne's Stabilization/Residential Program. This program is in Quebec. The recommendation is made by Psychologist Dr. Mathieu Murgatroyd of the New Brunswick OSI Clinic. The recommendation is sent by letter to the attention of Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette. Dr. Murgatroyd notes the following in his referral: 1. Lionel Desmond *"continues to struggle with disabling symptoms of PTSD that directly effects* [*sic*] *his social and occupational functioning."* 2. *"Client has significant problems functioning in daily living which impacts his social and occupational functioning."* 3. *"His social support network is limited."*	Exhibit P-000244 [pages 96 – 98]

		4. *"The goals of admission are for a medication reassessment; improving his coping skills, increasing his structure and daily activities and psychosocial rehabilitation."* 5. *"Once stabilized, client will have outpatient follow-up with his psychologist, his psychiatrist here at the OSI Clinic."* 6. *"He does not have a Family Physician."* 7. *"Client is not actively suicidal or homicidal. He is not a risk for aggression or violence. There are no present legal issues*." 8. *"Client is motivated to actively engage in treatment process and would highly benefit from psychosocial interventions*." 9. *"A teleconference is recommended prior to discharge for collaboration of care, review recommendations to ensure appropriate follow up."*	
December 21, 2015		Lysa Rossignol of the Chief Firearms Office of New Brunswick requested disclosure of RCMP Case # 20151535440 NK10111. The requested file documented the occurrence from November 27, 2015, where Shanna Desmond called the New Brunswick RCMP from her residence in Nova Scotia reporting that she was receiving concerning text messages from Lionel Desmond. She reported he was very depressed and made comments to her about committing suicide. Desmond wanted Shanna to "tell his daughter he will see her in heaven," that "it was time to go," "he will be "resting in peace"," and "going into the garage now" where he kept his firearm.	Exhibit P-000130 [page 9] Exhibit P-000084
December 22, 2015		On December 22, 2015, Cst. MacDonald reviewed both occurrence reports from Nova Scotia and New Brunswick (November 27 and 28, 2015). Cst. MacDonald noted that no updates from the firearms officer had been made or recorded by New Brunswick RCMP Cst. Richard on his file in relation to the disposition of the firearms (firearms return). An RCMP decision was made in favor of "safekeeping" "pending the outcome of the Ormoncto [*sic*] RCMP investigation." Cst. MacDonald's report noted:	CAN001751 Exhibit P-000087 [page 6]

	"• await update from Cst Richard / Oromoncto [*sic*] *RCMP (re: 20151535440)* *• return / dispose of firearm in possession of Guysborough District RCMP per direction of New Brunswick firearms officer."*	
December 23, 2015	On this date an RCMP Supplementary Occurrence Report is created by New Brunswick Firearms Liaison Officer Cst. Dennis Hachey. The report included a completed form titled "**DISCLOSURES TO FIREARMS OFFICERS**." The report also summarized the event of November 27, 2015 (RCMP Investigation File # 20151535440).	Exhibit P-000083 [pages 6 – 9]
December 29, 2015	As a result of a "FIP" (Firearms Interest to Police) being recorded from the November 27, 2015, RCMP occurrence, Lionel Desmond's firearms licence is placed under review by the Chief Firearms Officer of New Brunswick. The review is assigned to New Brunswick Firearms Officer Joe Roper. Lysa Rossignol of the Chief Firearms Office of New Brunswick forwarded a "**REQUEST FOR TERTIARY INVESTIGATION**" to New Brunswick Firearms Officer Joe Roper. Along with the Request for Tertiary Investigation form her database note read: *"FIP Event 6187445 relates to case # 20151535440 NK10111. Event matched to licence 12325681 and assigned to NB AFO J. Roper. Licence 12325681 placed UNDER REVIEW. Disclosure attached to tertiary."*	Exhibit P-000131 [page 2] Exhibit P-000132 Exhibit P-000135 Exhibit P-000130 [page 9]
Late 2015/Early 2016	Shonda Borden, Shanna's sister, is told by her sister that she no longer wished to remain with Lionel Desmond. She stated the following in her evidence: *"**Q**. Do you know if there was ever sort of a specific time where she might have expressed to you that, look, she's going to end the relationship and they're going to completely separate? Did that ever come up?* ***A.*** *Yeah, so that happened a couple of times. You know, one time, you know, a couple of times she told me that she was done. Well, they both told me that they were done with each other. Where I would just say, Okay, well, you have to, you know, try to stick it out*	Transcript June 21, 2021 [pages 69 – 70]

		through sickness and through health, deal with it kind of thing. But then at the end, like late in 2015, early 2016, she was just like, I'm done with this, you know. I can't deal with this anymore. It's going on for too long. He's not getting the help that he really needs and I can't help him, you know. She used to be . . . He used to think that because she was a nurse that she would be able to help him but that's way out of her scope of practice. She just wanted to be done in the end."	
Jan. 4,	**2016**	**<u>Therapy session #6 New Brunswick OSI</u>** Shanna Desmond and Aaliyah attend this session with Lionel Desmond. The following note is made regarding the Regina Christmas trip: *"Mr. Desmond indicated his trip to Regina went generally well. However, he reported feeling paranoid a lot, especially while he and his family were on the plane."* Mr. Desmond again confirms his eagerness to attend the Ste. Anne's program. Shanna Desmond is supportive as well. After the session Dr. Murgatroyd speaks with Veterans Affairs Canada (VAC) Case Manager Maire-Paule Doucette, who confirms she received the December 15, 2015, referral. Marie-Paule Doucette requests a copy of Dr. Njoku's assessment.	Exhibit P-000244 [page 66]
January 4, 2016		**<u>Psychiatry Appointment #3 New Brunswick OSI</u>** Dr. Njoku, psychiatrist New Brunswick OSI. Shanna Desmond accompanies Lionel Desmond to this appointment. November 2015 is reported as "probably the worst time they've been together." However, the relationship and Lionel Desmond appeared "much more settled" over the recent Christmas Holiday. Lionel Desmond continues to report arguments with Shanna Desmond, irritability, disordered sleep, and nightmares. He is reported as remaining "very jumpy" and "experiences dissociative episodes most of the day." Mr. Desmond is motivated to attend the Ste. Anne's program and is described as presenting "much calmer, much less agitated."	Exhibit P-000244 [page 30]

January 4, 2016	Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette receives a December 15, 2015, letter from New Brunswick OSI Psychologist Dr. Mathieu Murgatroyd. The New Brunswick OSI team has recommended a referral for in-patient treatment and stabilization at the Ste. Anne's Hospital, Quebec. To support the referral, Ms. Doucette requests that Dr. Murgatroyd obtain a psychiatric report from Psychiatrist Dr. Anthony Njoku and provide it to Veterans Affairs Canada (VAC).	Exhibit P-000115 Exhibit P-000273 [page 16]
January 5, 2016	Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette contacts Lionel Desmond by phone. She wishes to schedule an in-person visit to complete the assessment and develop a rehabilitation plan. The client screening note reads: *a. "CM contacted client for purpose of scheduling a visit to complete AC assessment and develop rehab plan. He confirmed his availability for next week. CM also updated client on communication with OSI clinic: Recommendation for referral to in-patient treatment has been received, copy of Psychiatry report will assist with CM's Assessment and referral process. Client expressed he remains interested in the proposed treatment."* *b. "Client reported spending a good Holiday season in wife and daughter's company."* *c. "Client presented as calm and reported no further concerns or questions at the time."*	Exhibit P-000293 [page 1] Exhibit P-000292 [pages 3 – 4]
January 5, 2016	A report from New Brunswick RCMP Cst. Steven Richard relating to the November 27th, 2015, seized .223 rifle indicated: *"… **speak with Firearms Officer as it would not be advisable to return this firearm to Desmond.**"*	Exhibit P-000082 [page 7]
January 12, 2016	Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette attends Lionel Desmond's residence for a scheduled visit. However, he is not home. She is subsequently advised by him that he was out of the province to attend the funeral of a family member. The in-person assessment is rescheduled for January 26, 2016.	Exhibit P-000273 [pages 15 – 16]

January 14, 2016	**<u>Missed New Brunswick OSI Appointment #4</u>** Lionel Desmond misses his appointment. He did not call to cancel the appointment and could not be reached by phone.	Exhibit P-000244 [page 65]
January 16, 2016	Veteran Affairs Canada (VAC) Case Manager Marie-Paule Doucette completes the Area Counsellor Client-Centred Assessment. Highlights from this assessment include: 1. *“Back pain – any physical activity or heavy lifting causes shooting pain, veteran describes the pain as sometimes crippling. Unexplained chest pains, without warning. Veteran unsure what may be causing this, but recognizes it could be stress related.”* 2. *“**Medication*** *Medicinal marijuana 10g/day PTSD”* 3. *“Client is making efforts to wean off marijuana, using it only as he feels is needed, in preparation for possible in-patient treatment. Client was previously prescribed a number of psychoactive drugs (e.g. Effexor, Risperidone, etc.) by military psychiatrist. He has since advised his new Psychiatrist - Dr. Njoku at OSI clinic - that he is no longer taking them because of too many undesirable side effects.”* 4. Answers “Yes” to question “Do you or others in your life have concerns about how you are coping with stressors you may be experiencing?” 5. Answers “Poor” to “In general, would you say your mental health is:” 6. Answers “Yes” to feeling “down,” “Tense or anxious most of the time?” “… for more than two weeks?” 7. Under “**Mood**” he reports “Sadness,” “Isolation/Loneliness” and “Anxiety.” 8. *“Veteran reports feeling depressed most of the time. When in NB, he is mostly isolated from others given lack of informa* [*sic*] *supports/family and friends in the area. Veteran recognizes he has difficulty coping with current circumstances, in particular (temporarily) living apart from his wife and daughter.”*	Exhibit P-000291

9. Responds "Yes" to question "Have you noticed a change in your memory recently?"

10. Concerns are documented with respect to Lionel Desmond's "Concentration," "Comprehension" and "Memory."

11. "*Veteran descriebd* [*sic*] *inability to recall things like passwords, which he must write down, despite once having a "sharp" memory for numbers. He also said it takes longer for him to learn new things (e.g. musical chords). Veteran disclosed his most vivid memories are from his time serving in Afghanistan*."

12. Marie-Paule Doucette notes the following observations:

    "Veteran is cooperative, engages in meetings with CM. Writer often had to repeat questions for sake of clarity as he seemed to have comprehension difficulties. Veteran also tends to talk a lot as opposed to answering questions concisely. Speech is rather slow."

13. Responds "Yes" to "… difficulty with your day to day personal care?"

14. *"Running errands is difficult, particularly in Oromocto/Fredericton. Veteran experiences emotional difficulties if/when running into CF members in uniform. He tends to relie* [*sic*] *on spouse for this often. When alone, he does minimal grocery shopping or cooking. He described not having the motivation the* [*sic*] *prepare or eat important amounts of food."*

15. *"Veteran maintains a certain level of independence, but appears to run into barriers as a result of his mental and physical health difficulties."*

16. Lionel Desmond declines to respond when asked if he is satisfied with housing.

17. *"Comments: appropriateness of housing, issues affecting client/family, proximity to medical care, employment etc"*

18. *"Veteran wants to improve his communication skills, in particular within his spousal relationship. He said he cuts people off a lot, is not sure why, and would like to stop."*

	19. Responds "Yes" to question "Have irregular sleep?" 20. *"Interrupted sleep – 2 or 3 hours per night"* 21. *"Appetite goes with stress/loneliness"* 22. *"… alcohol intake has been problem."* 23. *"Veteran said he constantly feels tired, even when just waking up. He seldom feels like he has had enough sleep. He describes himself as a light sleeper who wakes up multiple times in the night."* 24. *"Veteran wants to decrease his intake of medicinal marijuana, as he feels 10 g intake each day turns him into a "zombie". He is also hoping for a change of scenery, though he is unsure where would be a good place for him to live."* 25. "*Veteran is unable to work at this time due to his reported health conditions – PTSD, significant back pain."* 26. "*Veteran reports limited skills in job searching and planning for employment."* 27. Responds "Yes" to question "Do you have any concerns with your current level of education?" 28. Responds "Yes" to question "Are you having any difficulty with your family circumstances or social supports?" 29. Responds "Somewhat weak" to question "How would you describe your sense of belonging to the community?" 30. *"Veteran is experiencing some marital difficulties. His wife and daughter reside with her parents/his in-laws in Nova Scotia and he travels between there and his home in Oromocto. He is trying to sell his NB home, but continues to spend some time there alone as his relationship with his in-laws is one he describes as difficult. Being around them in NS, Veteran said, tends to trigger his anger."* 31. *"Veteran currently has no hobbies or leisure activities. He does not belong to any community groups, nor does he appear to have a strong network of friends/family around him. He reports*	

	being dissatisifed [*sic*] *with this and would like to be more integrated into a community."* 32. *"Veteran is aware of OSISS Program* [Operational Stress Injury Support Services]*, has numbers to call, and is open to meeting with a peer support. He has yet to establish contact but would welcome CM contacting OSISS on his behalf. He occasionally participates in support group at Marijuana for Trauma office in Oromocto, yet said he is not completely in agreement with organization's general philosophy."* 33. *"Veteran appears to struggle mainly with the decline in his health and how it is preventing him from moving forward with his life. As previously stated, he also would like to increase, at some point, his sense of belonging to a community as it appears to have been greatly impacted by his premature release from the CF. Veteran is also challenged by the instability of his household (i.e. not living with his wife full time as she is away for school). He repeatedly spoke of how this is diffcult* [*sic*] *for him. CM gets the impression he has lost all sense of normalcy."* The last highlight of the Area Counsellor Client-Centred Assessment (#33) is significant. In that short paragraph, Marie-Paule Doucette appears to capture the complexity of Lionel Desmond's circumstances and the urgency of which interventions are needed. "He has lost all sense of normalcy." However, it is unfortunate that it has taken almost seven (7) months post military release before Veterans Affairs Canada (VAC) even begins to evaluate and understand Lionel Desmond's vulnerabilities. He lives with: 1) A sense of isolation 2) A sense of not belonging to a community 3) A lack of identity 4) An instability within the relationship with his wife and daughter 5) An ongoing state of mental health crisis Timely interventions are lacking to this point and will continue to be a theme leading up to the tragic events of January 3, 2017. This Area Counsellor Client-Centred Assessment contains valuable historical information about Lionel Desmond's circumstances and state of crisis. Despite this, no thought is given to sharing this document with him, or any other service provider. As well, no	

thought is given to obtaining his consent to share this valuable information.

The role of the Veterans Affairs Canada (VAC) case manager is to collaborate with the veteran in coordinating care. This is done by collectively identifying resources and service providers who are available to assist a veteran in their rehabilitation.

Lionel Desmond was a complex case. He had many struggles and crisis to grapple with simultaneously. This complexity appears to have been comprised of at least 12 central elements:

1. Mental health (PTSD, Depression, Mixed Personality Traits)
2. Substance abuse (Alcohol)
3. Cognitive limitations
4. Domestic/marital discord and breakdown
5. Anger management issues
6. Emotional deregulation
7. Isolation/lack of social supports
8. Lack of family supports
9. Employment/education barriers
10. Housing
11. Racial trauma
12. Physical health (chronic backpain)

Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette is a registered social worker. She began her public service career in 2011 as a parole officer with Correctional Services Canada. She maintained that position until she was transferred to Veterans Affairs Canada (VAC) in September of 2015.

Within two (2) months of starting her new role, she was assigned her first group of clients. She was initially assigned approximately six (6) clients which included Lionel Desmond. In relation to the circumstances under which a veteran may be assigned a case manager, Marie-Paule Doucette testified:

Transcript June 22, 2021 [page 32]

"For the most part, when someone is referred to a case manager, there is sort of overlapping medical and psychosocial needs that need to be addressed and then there's the vocational aspect, as well."

In terms of the caseload of a Veterans Affairs Canada (VAC) case manager in 2015-2016, Marie-Paul Doucette testified:

Transcript

	"So as a new case manager that was coming on board, naturally, I had a smaller caseload at that time than someone who had been there for a number of years, but within a year's time, I had definitely somewhere between 35 and 40 clients. Something of that nature." "*We were always told from the beginning that VAC's aim was 25 veterans to one case manager. Unfortunately, that's not something that I've experienced. And, I mean, I understand that there was a shortage of resources when I arrived; therefore, probably more veterans in need of services than resources that could be provided at the time*."	June 22, 2021 [pages 59 – 60]
	Marie-Paule Doucette further testified that:	
	a. "… I agree that there was a complex theme to his situation …"	Transcript June 23, 2021 [page 70]
	b. "*Yeah. It had some level of complexity*."	Transcript June 23, 2021 [page 69]
	Family Intervention Services/Domestic Violence During her 14 months as Lionel Desmond's Veterans Affairs Canada (VAC) case manager, Marie-Paule Doucette became aware that there was a recurring and constant theme of marital breakdown and tension between him and his wife Shanna Desmond. Select highlights from Ms. Doucette's testimony include:	
	a. "I think that at the time that I met him and I completed the assessment that he was clear about the fact that his relationship was difficult and that that sort of remained a theme as I was working with him."	Transcript June 23, 2021 [pages 43 – 44]
	b. "*I can say that, you know, after working with him for some time that he was demonstrating concerns that their relationship might break down. He talked about his wife mentioning divorce papers in a sort of joking way, and that upset him*."	Transcript June 23, 2021 [page 48]
	It is notable that Ms. Doucette never received training from Veterans Affairs Canada (VAC) in the areas of identifying family intervention crisis or intimate-partner violence. She testified:	

	a. *"Would I have liked to have more training in that? Specific to intimate partner violence, I think that could've been beneficial."*	Transcript June 23, 2021 [page 39]
	b. *"If there was a training specific to detecting risk of homicidality, perhaps that could've been helpful."*	Transcript June 23, 2021 [page 40]
	Ms. Doucette as case manager never did canvass with Lionel Desmond, for his consideration, that she could directly identify and seek out provincial services in the areas of intimate partner violence, family crisis, parenting, couples counselling, etc. This was seemingly left for the clinical care manager who does not meet with Lionel Desmond until November 30, 2016, one (1) month prior to the tragic events of January 3, 2017. The clinical care manager resource is put in place much too late to assess and coordinate the essential interventions of intimate partner violence and family crisis services.	
	<u>Isolation/Social Support</u>	
	As Lionel Desmond's case manager, Ms. Doucette became aware of the recurring barrier, which was isolation and the lack of sufficient social supports. She testified:	
	a. *"Again, I was meeting him in Oromocto where he lived alone. He didn't engage much with the community around him. That was information that he freely reported. And as far as close supports, like I said before, so we always try to find out like who are the people around you that you can lean on, that can help with different aspects of your rehabilitation. And his answer to that was pretty much my wife but, you know, our communication isn't really the best right now. So he suggested that he wouldn't rely on her because of that or as much because of that."*	Transcript June 22, 2021 [page 92]
	b. *"Well, at the time that I did the assessment, that I first met him, isolation was definitely . . . or the feeling of being isolated was definitely something that was observed."*	Transcript June 23, 2021 [page 52]
	c. *"And he would've reported, maybe not in these exact same words that, yeah, he didn't have a whole lot of social supports."*	

	In her 14 months as case manager, Ms. Doucette did very little to directly coordinate provincial resources which could have assisted Lionel Desmond with breaking down the barrier of isolation. She did contact Operational Stress Injury Support Services (OSISS) on his behalf. However, Lionel Desmond had also directly expressed to her an interest in enrolling with the provincial programs of "Trauma for Healing" and "Wounded Warriors." Ms. Doucette did not offer any direct assistance in making these connections. When asked at the Inquiry whether or not she reached out to any entities other than OSISS, she stated: "*Me, specifically? I don't believe so, no*." Heavy, and perhaps over, reliance was placed waiting for and delegating these tasks to the clinical care manager who, due to bureaucratic barriers, could not be retained in a timely manner.	Transcript June 23, 2021 [page 55]
January 17, 2016	On this date, Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette summarizes the complexity of Lionel Desmond's transition to civilian life. Significant fragility and risk are identified with respect to Lionel Desmond's current circumstances. Ms. Doucette's case plan entry titled "**Overview Of The Situation**" reads: a. "*Mr. Desmond is a 32 year-old CF veteran who was medically release d* [*sic*] *in 2015/07 as a result of a PTSD condition. He requested and was approved for VAC rehabilitation services as a result of barriers caused by said condition. In particular, the veteran reports great difficulties controlling his emotions and his generally heightened anxiety often leads to, or at least places him at ongoing risk of, anger outbursts or panic attacks. The veteran also reports difficulties in his marriage of 10 years (e.g. poor communication, conflict) and struggles with the instability of his living arrangements."* b. "*His home, in Oromocto NB, is for sale and any amount of time he spends there on his own causes him to feel lonely and to isolate given very limited local supports. He frequently travels between Oromocto and Antigonish NS, where his wife (and daughter) is residing and completing her nursing degree."*	Exhibit P-000117 [page 1]

	c. *"The veteran currently presents as lacking the ability to cope with his emotional turmoil and chronic back pain limits his ability to lead the physically active lifestyle he once had and desires. He values his immediate family and his roles as husband and father."* d. *"The veteran has proven he is open to receiving psychological help. The mental health professionals he has connected with report an inability to begin working through his military related trauma due to ongoing instability (i.e. "disabling symptoms of PTSD"). For now, he maintains regular contact with his mental health team with hopes of soon engaging in the stabilization and structured treatment they have formally recommended."* Consistently at the forefront of Lionel Desmond's list of priorities is having a happy and healthy relationship with his wife and daughter. Under the case plan heading of "**Where Do You Want To Be?**" Ms. Doucette notes: *"Within two years, the veteran wants to develop positive communication skills to improve his marital relationship, be a good role and present model for his daughter, and increase his abilities for future employment."*	
January 19, 2016	**<u>Phone Contact New Brunswick OSI</u>** Dr. Murgatroyd contacts Lionel Desmond by phone. Mr. Desmond is in Ontario and attending the funeral of Shanna Desmond's uncle.	Exhibit P-000244 [page 64]
January 20, 2016	By way of formal letter dated January 20, 2016, Lionel Desmond is notified that his firearms licence has been placed under review. The letter specifically references the details of the November 27, 2015, RCMP occurrence File # 2015 1535440. It also enclosed a "**Medical Assessment by Physician**" form to be completed by Lionel Desmond's physician. There is no reference made to the Nova Scotia RCMP occurrences from November 18, 2015 (RCMP Investigation File # 20151494158) or November 28, 2015 (RCMP Investigation File #s 20151539202 & 20151539308). New Brunswick Firearms Officer Joe Roper stated:	Exhibit P-000135 Exhibit P-000132 Exhibit P-000131 [page 2] Exhibit P-000130

	"In the interest of public safety it is required that you now have completed and returned the attached medical assessment form, by your physician within ninety (90) days. Failure to do so will result in the revocation of your firearms license."	Exhibit P-000135 [page 4]
January 22, 2016	**Therapy Session #7 New Brunswick OSI** Dr. Murgatroyd describes Lionel Desmond as doing "generally well" and that "he continues to work on building his relationships with his wife and daughter." Mr. Desmond advises that they have been arguing lately and this has led to anxiety attacks. He continues to be back and forth between Oromocto, New Brunswick, and Antigonish, Nova Scotia. As a result, he has requested that his next appointment with Dr. Njoku take place by phone.	Exhibit P-000244 [page 63]
January 25, 2016	**Phone Contact New Brunswick OSI** Lionel Desmond advises Dr. Murgatroyd that he is travelling to New Brunswick as "he needed a little bit of time on his own, since he and his wife have been arguing."	Exhibit P-000244 [page 62]
January 26, 2016	During the January 26, 2016, assessment meeting, Ms. Doucette completes the Regina Risk Indicator Tool. Lionel Desmond's score is now 22/65. This places him at the "High Risk" category for an unsuccessful re-establishment into civilian life. "High Risk" is the highest risk level on the tool. It is notable in the seven (7) month period following his military release his risk level has risen. He scored 14/65 on May 25, 2015, one (1) month prior to his release from the Canadian Armed Forces (CAF). At that time, he was in the "Moderate Risk" category. Ms. Doucette testified that when she administered the tool on January 26, 2016, she had the benefit of professional source information from New Brunswick OSI Psychologist Dr. Murgatroyd	Exhibit P-000277

	and Psychiatrist Dr. Njoku. Having such additional information adds to the reliability of the results given that testing is not totally based on Lionel Desmond's self-reporting. In explaining what the January 26, 2016, score represents, Ms. Doucette testified: *"It's more about what, how right now at this moment based on the information he's reporting, how can we expect him to do, basically, or to succeed in rehabilitation*." In notes prepared by Ms. Doucette after the January 3rd, 2017, tragedy she documented the following with respect to Lionel Desmond's marital situation during January of 2016: *"Veteran spoke of challenges in his marriage. He expressed struggles with living apart from his wife and daughter and spoke of how he looked forward to leaving Oromocto, a military town, behind. He described a* [*sic*] *conflictual relationships with his in-laws (wife's parents)."*	Transcript June 22, 2021 [page 96] Exhibit P-000299 [page 2]
January 27, 2016	On this date, Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette documents within the case plan the key "**Desired Outcome**." Of immediate concern is the recognized need to structure/coordinate key resources which will assist Lionel Desmond in addressing his emotional instability both before and after attending the in-patient program at Ste. Anne's. This stability was never achieved. *"In three to six months, the veteran will learn and try new coping strategies to address the emotional difficulties - particularly those related to anger, sadness, and loneliness - that are causing a disconnect with his loved ones. The changes will be made, to the extent possible, through his active participation in mental health counselling and psychoeducation."* *"Despite participation in residential treatment (where both counselling and psychoeducation took place), the veteran does not appear to have effectively addressed his significant emotional difficulties. Work in this area is ongoing."* As well, Ms. Doucette reviews the merits of the December 15, 2015, New Brunswick OSI referral for in-patient treatment at Ste. Anne's Hospital, Quebec. She consults a Veterans Affairs Canada (VAC)	Exhibit P-000117 [page 2] Exhibit P-000117 [page 17]

	Regional Mental Health Officer (RMHO) and the admissions nurse at Ste. Anne's Hospital. A portion of Ms. Doucette's progress note from this date reads:	
	"Writer advised RMHO the referral came highly recommended by the veteran's team at the Fredericton OSI clinic in order to [*sic*] *for him to stabilize emotionally and begin trauma related treatment in a structured environment. Writer has discussed the veteran's referral with the facility's Admissions Nurse. The RMHO indicated she reviewed, in preparation for this consult, a Psychiatric report on file as well as writer's recent AC assessment. She is of the opinion there is significant evidence in favour of in-patient treatment as a good starting point for psychosocial rehabilitation in this case."*	
	In the early stages of developing the case plan, the expectation was that once Lionel Desmond completed the in-patient program at Ste. Anne's, Quebec, he would continue engaging in regular follow-up with the already established New Brunswick OSI team which included Psychologist Dr. Murgatroyd and Psychiatrist Dr. Njoku. Unfortunately, this did not work out as planned. On January 26, 2015, a Veterans Affairs Regional Mental Health Officer (RMHO) documented this expectation:	Exhibit P-000273 [page 15]
	"CM states that psychologist has indicated that veteran is not yet stable enough to begin actual trauma work. Psychologist and psychiatrist recommend Ste Anne's stabilization program and have committed to continuing to follow veteran upon discharge."	
	Further, at the Inquiry, Ms. Doucette testified to this original expectation:	
	"I mean it's probably wishful thinking but it would have been helpful had he been able to continue at least for a short time with the team at OSI New Brunswick, who knew him and would have had a chance to see him post treatment, you know, have their own observations about any changes, that sort of stuff. But I understand the limitations of what can be done provincially but it certainly would have been helpful if the same providers could have stayed in place, yes, that would have made the work a lot easier for me, and I believe for him as well."	Transcript June 23, 2021 [page 76]
	Revolving service providers and the lack of timely sharing of information/communication between health professionals is a recurring theme over the next year. It contributes to Lionel Desmond's spiraling instability.	

January 27, 2016	**<u>Psychiatry Appointment #4 New Brunswick OSI</u>** Lionel Desmond continues to significantly struggle with PTSD. He reports that being close to the military base acts as a trigger. This has been observed by Shanna Desmond. Dr. Njoku notes: *"Last week while he was there with his wife and his mom, he apparently became agitated again which caused concern to them."* Dr. Njoku conducts a third mental state examination and concludes that there is a need for regular follow-up appointments. Highlights of the examination include: 1. *"… he was not overly agitated today, not overly depressed either and appeared calmer*." 2. *"He probably needs to do some more work on basic stabilization and grounding skills to cope with some of his more hyper vigilant and hyper arousal symptoms and probably still needs a bit more psycho-education as well to understand his triggers which drive his aggressive responses*." 3. *"I'm continuing to offer follow up appointments regularly for him."*	Exhibit P-000244 [page 29]
February 2, 2016	Cst. Richard's RCMP report stated: *"Upon writers* [*sic*] *next day shift, will contact firearm center and to determine status of Firearm licence."*	Exhibit P-000083 [page 10]
February 5, 2016	**<u>Missed New Brunswick OSI Appointment #5</u>** Mr. Desmond did not call to cancel his appointment. When inquiries were made, he could not attend due to "bad weather."	Exhibit P-000244 [page 61]
February 9, 2016	The complexity of Lionel Desmond's condition is such that immediate in-patient interventions are deemed necessary. Since	Exhibit P-000117 [pages 5 – 6]

	leaving the Canadian Armed Forces (CAF), interventions to achieve emotional stability, mental stability, and psychosocial stability have been unsuccessful. The Veterans Affairs Canada (VAC) progress note reads: *"Efforts to treat OSI have been unsuccessful given lack of emotional, mental, and geographical stability. Both Psychologist anf* [*sic*] *Psychiatrist from Fredericton OSI clinic have recommended in-patient treatment, in writing, so veteran can find some stability and begin treatment with some structure. Client is agreeing to participate. He wants to improve his health for better functionning* [*sic*] *within the family unit. CM has reviewed documentation provided by OSI, discussed referral with veteran, and consulted with Regional Mental Health Officer who considers in-patient treatment to be appropriate for this case. Follow up care may be provided by OSI team in Fredericton. CM approves …"*	
February 15, 2016	**Missed New Brunswick OSI Appointment #6** Mr. Desmond did not call to cancel his appointment.	Exhibit P-000244 [page 60]
February 17, 2016	**Phone Contact New Brunswick OSI** Dr. Murgatroyd phones Lionel Desmond and inquires as to why he missed the last two (2) scheduled appointments. Mr. Desmond advised that he was in Nova Scotia and confused because of the holiday. He is reminded of his responsibility to attend appointments. He has abstained from using marijuana for four (4) weeks.	Exhibit P-000244 [page 59]
February 19, 2016	A second 3825 request for disclosure is faxed to the Guysborough RCMP Detachment requesting particulars of the November 18, 2015, occurrence (RCMP # 20151494158).	Transcript February 19, 2020 [pages 173 – 176] Exhibit P-000133 [page 2]
February 20, 2016	New Brunswick RCMP Cst. Steven Richard received an affidavit from New Brunswick Chief Firearms Officer noting that as of	Exhibit P-000037 [pages 8 – 10]

	December 29th, 2015, Lionel Desmond's firearms licence had been placed under review by New Brunswick Chief Firearms Officer pending investigation.	Exhibit P-000083 [page 11]
February 23, 2016	Dr. Smith receives a telephone call from Shanna Desmond stating that Lionel Desmond is angry and aggressive and "manic" and continues to be off his prescription medication. Dr. Smith then has a telephone call with Lionel Desmond. Dr. Smith's note from this call states as follows: *"Call to him → Strains are Stable $\bar{c}$ No Δ & No excessive Doses or inappropriate Strains or other meds & No return to Pharmaceuticals … No Signs of anger or mania (He disclosed her recent $ Problems & manipulation of events & Fraud (used his License To Sign Contract $\bar{c}$ Telephone Company … He was on Route To NS To Sort Legal issues out* *Felt his marriage was in Jeoprady* [*sic*]*."* In his testimony Dr. Smith read his note into the record as follows: *"Strains are stable with no change. No excessive doses or inappropriate strains or other medications and no return to pharmaceuticals. No signs of anger or mania. (This is his report.) He disclosed her recent money issues and manipulation of events and fraud. Used his license to sign contract with telephone company. He was en route to Nova Scotia to sort out legal issues . . . sort legal issues out. Felt his marriage was in jeopardy."* Dr. Smith is uncertain of the date of this telephone call but it would appear to be after December 3, 2015.	Exhibit P-000140 [page 17] Exhibit P-000140 [page 17] Transcript February 24, 2020 [page 138] Transcript February 24, 2020 [page 139]
February 23, 2016	Lionel Desmond meets with Dr. Smith prior to his attendance at Ste. Anne's Hospital in Quebec. At this time Lionel Desmond is no longer using medical marijuana. On this occasion, Lionel Desmond presents a Medical Assessment by Physician form to Dr. Smith. Under the heading "**Reason for Assessment:**" this form makes reference to the November 27, 2015, incident and states the following:	Exhibit P-000140 [page 18]

	"RCMP indicates that on the 27th of November 2015, they received a call from a female, her husband had sent her some text messages saying he was going to do harm to himself. He told her he was going to use a firearm and was on his way to the garage, this is where they are stored. He is a military veteran and has PTSD, he told her to say goodbye to their daughter and he would see her in heaven. Police attended the residence; our client met with them and said he did not have any intention of hurting himself, but that he is very depressed, he is concerned for his wellbeing. He was driven to the hospital, where he was seen by a Doctor" Dr. Smith is unaware of any other interaction that Lionel Desmond had with the RCMP. Dr. Smith completes the form by checking the box which states that he has no concerns that the applicant may pose a safety risk to himself or others. Dr. Smith states "Non-Suicidal & Stable - No Concerns for Firearm usage c̄ Appropriate License" Dr. Smith stated that he actually did not believe that Lionel Desmond would be granted a firearms licence and believed that he was only "a link in the chain of decision-making." Dr. Smith indicated that he formulated this view for the following reasons: *"That's a complex answer but, you know, he was very upfront with his feelings; he wasn't an alcohol or drug user; he was very open with his feelings; and he had things to live for. He had a group of friends. He loved his daughter at least and . . . anyway, I didn't see any of the instability. His suicidal thinking had dropped dramatically and my analysis of stable and unstable is based on those kinds of pieces of information."* Dr. Smith was never contacted by the New Brunswick Chief Firearms Office or any firearms officer in New Brunswick.	Transcript February 24, 2020 [page 157] Transcript February 24, 2020 [page 163] Transcript February 24, 2020 [page 158]
February 26, 2016	Cst. Richard spoke with Lysa Rossignol. Rossignol advised that New Brunswick Firearms Officer Joe Roper was assigned to review Lionel Desmond's firearms licence. Rossignol requested Cst. Richard to follow up with Roper in a few weeks.	Exhibit P-000083 [page 11]
February 29, 2016	**Phone Contact New Brunswick OSI**	Exhibit P-000244

	Lionel Desmond is noted as spending most of his time in Antigonish. He continues to abstain from marijuana and alcohol while he awaits admission to the Ste. Anne's Clinic. He finds doing puzzles helps him relax.	[page 58]
February 29, 2016	The completed Medical Assessment by Physician form is received by the New Brunswick Chief Firearms Office. The form was completed and signed by Dr. Paul Smith on February 23, 2016. Dr. Paul Smith is a physician in Fredericton, New Brunswick. In 2014 he became involved with an organization known as "Marijuana for Trauma." This group assisted various people including military veterans suffering from both physical and psychological trauma. Veterans such as Lionel Desmond were prescribed cannabis and offered peer support groups set up with volunteers acting as "coaches." Dr. Smith checked the box indicating: "**NO**, I have no concerns that the Applicant named above may pose a safety risk to himself/herself or others." Under the comments section Dr. Smith wrote: "Non-Suicidal & Stable - No Concerns for Firearm usage c̄ Appropriate License" A database entry from New Brunswick Firearms Officer Joe Roper on this date stated: "Client event (6187445) severity lowered :" An entry made by Joe Roper on the "**TERTIARY INVESTIGATION REPORT**" stated: *"At this time the client seems to have his mental health in order and based on the doctors* [*sic*] *assessment there does not seem to be any further problems. At this time the license is being reinstated."* On this date Lionel Desmond's Possession and Acquisition Licence is reinstated.	Exhibit P-000135 [pages 1 – 3] Exhibit P-000131 [page 2] Exhibit P-000132 [page 1] Exhibit P-000135 [page 3] Exhibit P-000130 [page 9] Exhibit P-000135 [page 1]
February 29, 2016	Lionel Desmond is officially accepted into the in-patient Stabilization Program at Ste. Anne's Hospital, Quebec. It is originally anticipated that there will be a four (4) to five (5) week waiting period before admission. Lionel Desmond is instructed to discontinue medical marijuana and alcohol consumption in the four (4) weeks leading up to admission.	Exhibit P-000117 [page 17]

	Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette contacts Lionel Desmond by phone. They discuss the Ste. Anne's referral and the community resource which is OSISS. Portions of her progress note include: *a. "He stated he is managing and is looking forward to getting into treatment at Ste-Anne's hospital. He said "it's just something I got to do"."* *b. "He understands his mental health will be the focus of the treatment."* *c. "CM asked if he has touched base with OSISS contact she had provided. He said yes, that he had attended a group session while in Oromocto. He is considering maybe following up at some point, but for now is helping out with his daughter in NS."*	
March 1, 2016	Lysa Rossignol contacts Dianne Campbell in the Nova Scotia Chief Firearms Office requesting the information from the November 18, 2015, occurrence. Ms. Campbell faxes a third 3825 request.	Transcript February 19, 2020 [pages 173 – 176] Exhibit P-000133 [page 2]
March 7, 2016	**<u>Missed New Brunswick OSI Appointment #7</u>** Lionel Desmond has now missed his seventh appointment with the New Brunswick OSI Clinic in nine (9) months. No explanation is offered. Dr. Murgatroyd contacts Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette for an update on the Ste. Anne's referral.	Exhibit P-000244 [page 57]
March 9, 2016	**<u>Phone Contact New Brunswick OSI</u>** Lionel Desmond expressed concerns to Dr. Murgatroyd about information he received from Veterans Affairs Canada (VAC) Case	Exhibit P-000244 [page 56]

		Manager Marie-Paule Doucette. Mr. Desmond is worried about his current financial situation. He was told that normally he would have to pay the Ste. Anne's travel fees up front and wait for reimbursement. He continues to abstain from marijuana and alcohol.	
March 9, 2016		Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette phones Lionel Desmond to discuss his acceptance into the Ste. Anne's program. Portions of her progress note include: *a. "He is concerned about the time it is taking for him to be updated. CM attempted to reassure him by stating she has initiated communication withe* [sic] *the Admissions Nurse and is awaiting her response. He seemed appreciative of this, however did rant about how difficult it is for him to be off his medicinal marijuana and not know when he will begin treatment."* b. *"With respect to travel plans, veteran explained to CM why he is unable to pay his flight upfront and await reimbursement."*	Exhibit P-000117 [page 16]
Mar. 9,	**2016**	Dr. Murgatroyd contacts Teresa Rodrigues, intake nurse at the Ste. Anne's Hospital. There are only ten (10) beds total to serve the nation-wide program. There are no spots available for Mr. Desmond currently.	Exhibit P-000244 [page 56]
March 23, 2016		**<u>Phone Contact New Brunswick OSI</u>** Lionel Desmond advises Dr. Murgatroyd that his Ste. Anne's admission is delayed until May 2016. As a result, he advised the Ste. Anne's intake nurse that he was going to restart marijuana. He is not interested in medication at this time and he is going to remain in Antigonish. As a result, Dr. Murgatroyd determines that further follow-up appointments will take place by telephone.	Exhibit P-000244 [page 55]
March 2016		Upon graduation from the nursing program at St. Francis Xavier University, Shanna Desmond is hired at St. Martha's Regional Hospital. Shanna and Aaliyah Desmond begin to stay at the home of her parents, Ricky and Thelma Borden, in Upper Big Tracadie until	Exhibit P-000170 [pages 2 - 3]

	they are able to find a home of their own. Lionel would later move into the home upon his return from Ste. Anne's Hospital.	
April 4, 2016	**<u>Phone Contact New Brunswick OSI</u>** Lionel Desmond advises Dr. Murgatroyd that the past week has been "distressing." He expresses concern over owing approximately $8,000.00 in taxes and other outstanding bills. He is now having doubts that he will be able to commit to the Ste. Anne's program due to financial reasons. He is seeking to delay his admission until June 2016.	Exhibit P-000244 [page 54]
April 5, 2016	There has been no contact between Lionel Desmond and his Veterans Affairs Canada (VAC) case manager in approximately a month. Lionel Desmond's Ste. Anne's admission date has been delayed. The Ste. Anne's admissions nurse has been in contact with him and advised that the new expected date for admission is late April, early May. Lionel Desmond explains that Shanna Desmond's nursing graduation is on May 1st, it is important to him, and he does not want to miss it. Lionel Desmond is not coping well. In a phone call to Ms. Doucette, he expresses various concerns. Portions of Ms. Doucette's system entry include: a. *"CM tried to engage veteran in conversation reagrding* [*sic*] *his upcoming admission. He advised he would be asking to have it postponed, given stressors he is epxeriencing* [*sic*] *related to his finances and his house being on the market."* b. *"As a result, he does not feel comfortable going to treatment without his housing/financial concerns having been addressed. CM offered assistance to help alleviate the stress he was under (i.e. help him communicate with this representative to explain his reality). He declined this help and was adamant he needed to delay his treatment start date."* c. *"He stated he wants to engage in treatment at a time when he has "a clear mind"."*	Exhibit P-000117 [page 15]

April 7, 2016	Lysa Rossignol of the New Brunswick Chief Firearms Office requested disclosure of the November 18, 2015, Nova Scotia RCMP occurrence (RCMP Investigation File # 20151494158). This Nova Scotia occurrence had generated a separate Firearms Interest to Police entry (FIP). Nine (9) months later in an email dated January 9, 2017, to Derek Eardley, New Brunswick Chief Firearms Officer, the following is stated: *"This occurrence also generated a FIP notification but was sent to the CFO Nova Scotia, as this was the jurisdiction of the incident. Delays in disclosure by police resulted in the information only being received by the CFO on 14-Apr-2016."* The New Brunswick Chief Firearms Office had already been aware and concluded their investigation relating to the Firearms Interest to Police (FIP) from the November 27, 2015, New Brunswick occurrence (RCMP Investigation File # 20151535440). Despite the November 18, 2015, Firearms Interest to Police (FIP) incident being first in time it had not been previously reviewed or considered by the New Brunswick Chief Firearms Office or the Nova Scotia Chief Firearms Office.	Exhibit P-000130 [page 9] Exhibit P-000132 [page 1] Exhibit P-000131 [page 2]
April 13, 2016	Cst. Len MacDonald reviewed the Oromocto RCMP file from November 27, 2015 (# 20151535440) and noted the licence review of Lionel Desmond was being handled by New Brunswick Firearms Officer Joe Roper. Roper contacted Cst. MacDonald and advised he would investigate the Oromocto file and determine what action would be taken and advise what to do with the .308 Savage rifle firearm SN # H078347. Cst. MacDonald's RCMP report again noted: *"• await update from Joe Roper (Canadian Firearms Center @ 506-847-6258)* *• await update from Cst Richard / Oromoncto* [*sic*] *RCMP (re: 20151535440)* *• return / dispose of firearm in possession of Guysborough District RCMP per direction of New Brunswick firearms officer."*	Exhibit P-000087 [page 6]

	On the same date New Brunswick Firearms Officer Joe Roper made the following database entry: *"RCMP Nova Scotia, Canso Detachment, Cst. Len MacDonald on April 13, 2016, called requesting a disposition on the firearms he seized from the father-in-law of Mr. Desmond back when the incident about his mental health was a concern. RCMP in Oromocto has contacted them and asked they seize a Savage Bolt Action Model Edge Ser. #H078347. This was completed and file # 2015-1494158 was created. In February the client had completed a medical assessmnet* [*sic*] *and the license could have been reinstated, but was waiting for this NS file to be cleared. Cst. MacDonald was advised that the firearm can be returned to the client's father-in-law and the FIP will be cleared. JWR"* It should be noted New Brunswick Firearms Officer Joe Roper may have been mistaken in the sequence of events and the full details of Nova Scotia RCMP File # 20151494158. The Nova Scotia November 18, 2015, occurrence which was referenced as File # 20151494158 was a separate and distinct incident occurring before the firearms were ever seized on November 27 and 29, 2015, respectively. Despite this Joe Roper refers to File # 20151494158 as being "created" after the firearms were seized. This should be viewed in relation to his April 18, 2016, e-mail to Cst. Len MacDonald (see below).	Exhibit P-000130 [page 9]
April 14, 2016	By way of e-mail Dianne Campbell of the Nova Scotia Chief Firearms Office forwarded the particulars of the Nova Scotia RCMP occurrence (RCMP Investigation File # 20151494158) to Lysa Rossignol of the New Brunswick Chief Firearms Office.	Exhibit P-000133 [pages 3 – 6]
April 15, 2016	**Therapy Session #8 New Brunswick OSI** **Continuity of Care Gap #5: Approximately 3 months (January 22, 2016, to April 15, 2016)** This is the first in-person contact between Mr. Desmond and the New Brunswick OSI Clinic in almost three (3) months (January 22, 2016). There has been zero assessment or treatment in three (3) months. Despite this, it is noted that the focus of therapy remains on stabilization. Mr. Desmond reports difficulties concentrating and relaying information. Most notably he reported the following to Dr. Murgatroyd:	Exhibit P-000244 [page 53]

	"He said he has been having nightmares lately, where he catches his partner cheating on him. He stated that some of the details are gruesome, for example finding the man's head on the floor. He is wondering if there is meaning behind the dreams, and whether his wife might be cheating on him. He said his wife laughed at him when he asked her about it rather than giving him a straight answer. He is considering whether the couple should go ahead and get divorced." Mr. Desmond continues to request that his Ste. Anne's admission date be pushed back until at least June or July 2016. Dr. Murgatroyd recognizes the "limited support and increasing stress at home" in Nova Scotia. Therefore, Mr. Desmond is asked if he would be interested in seeing a therapist in his Nova Scotia community. Mr. Desmond plans to discuss this possibility with his Veterans Affairs Canada (VAC) case manager this afternoon.	
April 15, 2016	Ms. Doucette has a home visit with Lionel Desmond on this date. Despite an earlier commitment to abstain from the consumption of marijuana, Lionel Desmond has now returned to using it. Consistent with past disclosures, he is overwhelmed with the stressors of marital breakdown, finances, and the need for mental health intervention. Selections from Ms. Doucette's screening notes include: *a. "He has been spending most of his time in Nova Scotia, with his daughter and his wife. They currently reside with his in-laws, who veteran has previously said are often in conflict with him. He stated he is worried about his marital relationship. He said he believes his wife has divorce papers in her possession that she often refers to jokingly. The jokes, he said, cause him to be concerned. Veteran stated his stress level is also heightened by having all of the family's financial responsibilities."* *b. "Discussed with veteran his decision to delay in-patient treatment. He said he is aware he needs thi [sic] treatment as soon as possible, but has a number of responsibilities he cannot rely on anyone else to take on while he is away (i.e. bills, end of house sale contract with Brookfield). CM attempted to problem-solve with him and veteran was somewhat receptive to suggestions."*	Exhibit P-000117 [page 15]

April 18, 2016	The following firearms database entry is made on this date: *"FIP Event 6184442 relates to case # 20151494158 NS10015. Disclosure received from NS - Mental Health Act occurred on 2015/11/18. Medical assessment requested by NBAFO J. Roper on case # 20151535440 NK10111 and received on 2016/02/29 with no issues. Exclude complete."*	Exhibit P-000133 [page 2]
	By way of a short e-mail Lysa Rossignol contacted New Brunswick Firearms Officer Joe Roper regarding Lionel Desmond's firearms licence: *"Hi Joe,* *Licence placed back to valid.* *Lysa"*	Exhibit P-000133 [page 1]
	On the same date Cst. Len MacDonald received an e-mail from New Brunswick Firearms Officer Joe Roper: *"Hi Len* *Just wanted to confirm a file number from Nova Scotia 2015-1494158. I assume this is the file number created when you seized the Savage Edge Ser. # H078347 as a result of Mr. Desmond's actions here in New Brunswick?* *Mr. Desmond submitted a Medical Assessment form by a physician that advised he was of sound mine* [*sic*] *and what had happened was an isolated incident. His firearm license was reactivated and as such you can return the firearm seized by you. Thanks Joe"* It should be noted that New Brunswick Firearms Officer Joe Roper's assumption that File # 20151494158 was created once Nova Scotia RCMP seized Lionel Desmond's Savage Edge rifle SN # H078347 may have been in error. Roper phrases the statement in terms of a question suggesting that he may have mistaken or been unaware of the details on what occurred on November 18, 2015. He gives the impression that file incident 20151494158 occurred after the November 27, 2015, New Brunswick incident and simply detailed Nova Scotia RCMP involvement in seizing Desmond's Nova Scotia firearm.	Exhibit P-000090

	In other words, it implies that Roper may have mistakenly understood file incident 20151494158 was only an extension of the "isolated" New Brunswick occurrence of November 27, 2015. Did Joe Roper do an independent review of the November 18, 2015, Nova Scotia occurrence, or did he mistakenly think it was just an extension of seizing a firearm out of the November 27, 2015, incident? November 18, 2015, had in fact involved a separate wellness check where Desmond was reported in a "manic state." This was prior to Lionel Desmond's actions in New Brunswick on November 27, 2015. There may have been some confusion between New Brunswick Firearms Officer Joe Roper and Cst. Len MacDonald in this correspondence. Lionel Desmond's Savage Edge rifle SN # H078347 firearm was not seized as a result of the November 18, 2015, Nova Scotia occurrence (RCMP Investigation File # 20151494158). The Savage Edge rifle SN # H078347 was not seized until November 29, 2015, and as a result of the November 27, 2015, New Brunswick occurrence. (RCMP Investigation File # 20151535440).	
April 21, 2016	Cst. Len MacDonald made the following report: *"On April 21, 2016 Cst MacDonald recieved* [*sic*] *email notification from Firearms Officer Joe Roper that the investigation initiated by the Oromoncto* [*sic*] *RCMP was complete. Roper advised that health care profesionals* [*sic*] *had not* [*sic*] *concerns about Lionel Desmond's mental health and as a result Roper advised his firearms certifications had been reinstated. Roper directed Cst MacDonald to return Desmond's firearms.* *…* *• contact Desmond to arrange return of his firearm."*	Exhibit P-000087 [page 7]
April 22, 2016	Cst. MacDonald reported: *"On April 22, 2016 Cst MacDonald attempted to contact Desmond at the numbers listed on his PROS "persons tab" but was unable to reach Desmond.* *…*	Exhibit P-000087 [page 7]

	• *contact Desmond to arrange return of his firearm."*	
April 23, 2016	Shonda Borden recalls Lionel Desmond describing disturbing dreams to her wherein he has killed Shanna Desmond. Shonda Borden received the following text from Lionel Desmond on April 23, 2016. *"Hey bones it's for the best. ...she and I are changing for different reasons she's tired of this too…she hack in my Facebook fine this is my new one ok reason I put everything on Facebook is me and her don't communicate well so I am stressed to not eating and I need her to be happy with someone else because I dream that is wrong with this relationship between us…. Yes she loves her family but I am the issue she needs to delete from her mind. …..I'm not cheating it's just I have no control over my dreams nightmares of her with another guy and me hacking them so I need to be alone. …..I'm not abandoned her yes I ceased my account I'm triggering it's not going to stop so it is best for you and your family to know I am going to be divorced and homeless so nice knowing you"* And another text from approximately the same time where Lionel Desmond tells Shonda Desmond to tell Shanna, "Let her know i got eyes on a 22 magnum."	Transcript June 21, 2021 [pages 89 – 90] Exhibit P-000175 and Exhibit P-000176 Exhibit P-000182
April 25, 2016	**<u>Therapy Session #9 New Brunswick OSI</u>** Shanna Desmond phones the New Brunswick OSI Clinic requesting to speak with Dr. Murgatroyd and Dr. Njoku. Both are unavailable. As a result of her phone call Lionel Desmond requests that both of his consents be rescinded. He no longer authorizes New Brunswick OSI Clinic to speak with Shanna Desmond or collect/exchange information with her. Tensions appear to be rising between Lionel Desmond and Shanna Desmond. He has recently relocated to Oromocto, New Brunswick, following an "argument/conflict" with Shanna Desmond and her parents. He reports that things have "deteriorated in the household." The following note is made by Dr. Murgatroyd: *"According to him, his partner has been sharing sensitive/personal information about Mr. Desmond to her mom. This really upset Mr. Desmond and he feels he cannot trust his partner. He also indicated*	Exhibit P-000244 [pages 17 and 23] Exhibit P-000244 [page 52]

		that she has been "holding on" to divorce papers, which is also upsetting him. He feels that she is being manipulative and is unwilling to work on their relationship, as he believes she needs to engage in her own therapy but won't do so. Writer offered supportive listening. Finances continue to be a significant stressor, and he stated his partner spent a few hundred dollars, which she took from their joint account. He said this angered him because they have several bills to pay off. He indicated the argument led to his partner taking off with their daughter. He himself ended up leaving the residence and coming up to Oromocto. According to Mr. Desmond, she has been unwilling to talk to him over the phone during the past few days. They have been relaying information through her sister. He "froze" their joint account so that she could not spend any more money. He indicated he may consider filing for bankruptcy." Dr. Murgatroyd recognizes that Lionel Desmond needs to be seen more frequently in person at the New Brunswick OSI Clinic. Dr. Murgatroyd notes "it may well be worth beginning to address his PTSD." Curiously, this statement about "beginning" to address his PTSD is made despite Lionel Desmond having been involved with New Brunswick OSI Clinic for upwards of a year at this point. It is apparent that Lionel Desmond is overwhelmed by personal stressors such as his finances and efforts to sell his residence in New Brunswick. As a result, he again expresses a desire to postpone his Ste. Anne's admission. He wishes to begin neurofeedback treatment and is noted as not reporting suicidal or homicidal ideation.	
April 25, 2016		Veterans Affairs Canada (VAC) records indicate Lionel Desmond's last contact with Case Manager Marie-Paule Doucette was on April 14, 2016. Today Lionel Desmond calls looking to speak to her and is transferred to her voicemail. *"Client called to speak to CM. WT to CM voicemail."*	Exhibit P-000273 [page 14]
May 3,	**2016**	**<u>Missed New Brunswick OSI Appointment #8</u>** At the height of rising tensions with Shanna Desmond, Lionel Desmond does not attend his scheduled session with Dr. Murgatroyd. When contacted by phone he advises that he was confused as to the dates.	Exhibit P-000244 [page 51]

			The relationship with Shanna Desmond continues to spiral downward as does Lionel Desmond's mental health. Dr. Murgatroyd notes: *"He stated he and his wife have communicated through text message, but that it was not very constructive and he said it upset him. He indicated he called the VAC crisis line in order to talk to someone, since it was after hours. He did not express SI/HI."* On this same date Dr. Murgatroyd contacts Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette. A voicemail is left "expressing concerns about Mr. Desmond who is experiencing significant financial stress." *"… Mr. Desmond is experiencing significant financial and said he would likely have to go to a food bank due to a lack of funds."*	
May	**9,**	**2016**	**Joint In-person Session with Dr. Njoku and Dr. Murgatroyd New Brunswick OSI** Both Dr. Murgatroyd and Dr. Njoku meet with Lionel Desmond. The goal is to discuss plans for "ongoing care during this difficult period for Mr. Desmond." Lionel Desmond's mental health continues to deteriorate. His anger is directed at Shanna Desmond. The following note is made: *"Mr. Desmond was very agitated today. He was very angry with his current situation, in particular regarding his wife and their financial situation. His anger was noticeable during the session and both the writer and Dr. Njoku tried to bring him down. At times it was difficult to redirect him, as he kept circling back to his situation and how his wife cannot be trusted as she is ruining him financially."* *"We also tried to get him to focus on actions, and problem solving, rather than obsessing and dwelling on his problems which results in him escalating and becoming angry. We brainstormed different options, but let Mr. Desmond lead the way. He said he needed to go get information at the bank about his finances, and the process of filing for bankruptcy. He plans on going to the Foodbank tomorrow to ensure he has enough food in the house."*	Exhibit P-000244 [page 50]

	Lionel Desmond discloses that he called Ste. Anne's directly to move his referral forward. As well, during this meeting "Dr. Njoku was able to convince him to start a new medication, Abilify, 2mg ..." After the session Dr. Murgatroyd updates both Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette and Ste. Anne's Intake Nurse Teresa Rodrigues.	
May 9, 2016	**Psychiatry Appointment #5 New Brunswick OSI** **Continuity of Care Gap #6: Lack of Consistent Psychiatry Resources: In excess of 3 months (January 27, 2016, to May 9, 2016)** Despite previous acknowledgements that Lionel Desmond would benefit from having "follow up appointments regularly" he has not been assessed by Dr. Njoku in over three (3) months. Dr. Njoku specifically notes "it has been difficult to consistently maintain therapy with him." This has "left him rather chaotic." The lack of consistent mental health intervention appears to coincide with a return to Lionel Desmond's marital breakdown, heightened anger, agitation, irritability, hostility, anxiety, and paranoid accusations directed towards Shanna Desmond. Various highlights from Dr. Njoku's report include: 1. *"Today he came in very upset, angry with lots of paranoid sounding accusations against his wife and a strong feeling of being victimized and being cheated financially by her. It was difficult to clarify the viscosity of his accusations, but what was clear was the degree of anger irritability and hostility."* 2. *"I saw him accompanied by Matthew* [Mathieu] *his therapist and on review he was very agitated, very irritable, difficult to distract and settle, but did not express any homicidal or suicidal thoughts. He was quite anxious and depressed in affect."* 3. *"Lionel hasn't really been able to utilize most of his relaxation strategies and he has not stayed in New Brunswick consistently long enough to benefit from his treatment here. He has been resistive to the idea of being on medications but today accepted Abilify 2 mg daily in the hopes that this would calm his agitation, perhaps soften his suspiciousness and*	Exhibit P-000244 [page 28]

	allow him more calmly make rational decisions about his future plans." 4. *"… he may benefit from a clinical case worker who could help him set up some structures and routines and perhaps work with him towards applying his relaxation strategies."*	
May 10, 2016	As a result of Lionel Desmond's firearms licence no longer being under review, the firearm which was seized by Cst. Len MacDonald on November 29, 2015, was secured and packed on May 5, 2016. On May 10, 2016, Sgt. Addie Maccallum mailed Lionel Desmond's .308 Savage rifle SN # H078347 firearm via Purolator to J Div. West District NB.	Exhibit P-000037 Exhibit P-000087 [page 8]
May 12, 2016	New Brunswick RCMP Cst. Steven Richard followed up with New Brunswick Firearms Officer Joe Roper regarding Lionel Desmond's firearms review. The following e-mail was sent by Joe Roper to Cst. Richard: *"Hi Steve* *Mr. Desmond has submitted medical information from his physician who has advised he is now not a threat to himself or others. As a result his firearms license was reinstated. He can now possess firearms. If you require anything else you can give me a call at 506-847--6258 or toll free 1-800-731-4000 ext 6019. Thanks Joe"* Cst. Richard then contacted Lionel Desmond and advised he could pick up his firearm. The following day Desmond attended the Oromocto RCMP Detachment and retrieved his firearm. RCMP report noted: *"At this time, file can be concluded."*	Exhibit P-000083 [page 12]
May 16, 2016	**<u>Missed New Brunswick OSI Appointment #9</u>** Without explanation Lionel Desmond does not show for his scheduled appointment with Dr. Murgatroyd. Again, it is another example where missed appointments tend to coincide with rising tensions with Shanna Desmond.	Exhibit P-000244 [page 49]

May 13, 2016	Veterans Affairs Canada (VAC) records indicate Lionel Desmond called looking to speak to Case Manager Marie-Paule Doucette and is transferred to her voicemail. *"Veteran calling for CM - warm transferred to her voice mail."*	Exhibit P-000273 [page 14]
May 18, 2016	Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette again meets with Lionel Desmond. He has now changed his mind and "decided he would like to get to treatment sooner than later." It is arranged that he will begin the Ste. Anne's program on May 30, 2016. Again, Lionel Desmond is very overwhelmed with his finances and the ongoing conflict with his wife Shanna Desmond. Select highlights from Ms. Doucette's progress notes include: *a. "CM also discussed with veteran his feelings about going to treatment, potential length of stay in Ste-Anne, etc. His biggest concern seem to be related to what might happen in his absence. House is for sale and his financial situation is unstable to the point of considering bankruptcy."* b. *"Veteran confirmed he recently started taking medication as per psychiatrist's recommendation, to help stabilize his symptoms which have been exacerbated by conflict with his spouse. He is not keen on continuing, but agreed that taking the medication until he at least is in the care of professionals in Ste-Anne is something he can do."* Inconsistent compliance and routine monitoring of compliance with mental health medications is and will continue to be a recurring factor in Lionel Desmond's instability.	Exhibit P-000117 [pages 14 – 15]
May 19, 2016	On this date, Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette seeks and is granted approval for an exceptional pre-payment request to cover Lionel Desmond's travel cost associated with the Ste. Anne's program. Lionel Desmond has continuously reported significant financial hardship. Select portions of Ms. Doucette's database entry include: *a. "Financial hardship is evident in this case."*	Exhibit P-000273 [page 14]

	b. *"Veteran has been in crisis over financial situation for some time. He has fallen behind on bill payments and is now looking into options for consolidating increasing debtload* [*sic*]. *Without help, he may be forced to declare bankruptcy. Veteran has struggled to meet his own basic needs recently and relied on services of a local foodbank. He also opted to participate in some psychological appointments over the phone as he did not have gas money to get to OSI clinic."*	
May 19, 2016	Lionel Desmond calls Dr. Murgatroyd. His Ste. Anne's admission is now set for May 30, 2016. He remains overwhelmed by several stressors: 1. *"… he is looking into filing for bankruptcy …"* 2. He wishes to*:* *"… visit his daughter before he leaves. … He said his mother is willing to go pick his daughter up, as a way for him to avoid contact and possible conflict with his wife."* 3. Medication continues to make him "feel nauseous."	Exhibit P-000244 [page 49]
May 20, 2016	*"On May 20, 2016 Cst MacDonald received confirmation from the Oromoncto* [*sic*] *detachment that Desmond's firearm had been returned."* RCMP report noted: *"Matter for conclusion."*	Exhibit P-000087 [page 9]
May 20, 2016	On this date, Lionel Desmond's mental health deterioration and ongoing marital conflict feature prominently in his phone call with Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette. He is clearly not coping well. Ms. Doucette is prompted to assess his personal safety and obtains his permission to contact treating New Brunswick OSI Psychologist Dr. Murgatroyd. Portions of Ms. Doucette's progress note read: *"He was* [*sic*] *expressed he was having a hard day, described some hurtful communication he had with his spouse today and stated she has ruined his life. CM attempted to help him strategize what he has to do before his departure for Mtl on 2016-05-30. However, he was*	Exhibit P-000117 [page 14]

		in no emotional state to be problem-solving. CM instead validated his frustrations and asked if he would benefit from connecting with his psychologist sooner, if possible. He provided verbal permission for CM to contact Dr. M. Murgatroyd today to see about any availability to connect with him. Assessment of personal safety. Veteran denies being a risk to himself or anyone else at this time."	
May 20,	**2016**	**<u>Continuity of Care Gap #7: Delay in Ste. Anne's Residential Treatment: More than 5 months (December 15, 2015, Referral date to May 30, 2016, Admission date)</u>** Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette contacts Dr. Murgatroyd. She "expressed concerns about Mr. Desmond." The following note is made by Dr. Murgatroyd: *"According to Ms. Doucet* [*sic*]*, Mr. Desmond had been in touch with his wife, which led to a significant argument between the two. She said he was highly distressed during their meeting. Ms. Doucet* [*sic*] *is worried Mr. Desmond will back out of his program at Ste. Anne's and was hoping the writer could contact Mr. Desmond before the long weekend."*	Exhibit P-000244 [page 49]
May 25, 2016		In the days leading up to his Ste. Anne's admission, Lionel Desmond's conflict and frustration with his wife Shanna Desmond continue to rise. His voice is elevated as he speaks with Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette. Ms. Doucette's progress notes read: *"He expressed he was having a bad day and proceeded to tell CM how his wife continues to "play games" with him and mess with their already precarious financial situation. It took many attempts before CM could diffuse the situation as he kept raising his voice as he ranted his frustrations."*	Exhibit P-000117 [page 13]
May 27, 2016		**<u>Phone Contact New Brunswick OSI</u>** Mr. Desmond advises Dr. Murgatroyd that he remains committed to attending Ste. Anne's in the coming days. In terms of the current dynamic between Lionel Desmond and his wife Shanna Desmond, Dr. Murgatroyd makes the following note:	Exhibit P-000244 [page 48]

	"He has been in touch with his wife. It seems as though they are on speaking terms again. According to Mr. Desmond, she agreed to pay some of their bills. Mr. Desmond hopes they can eventually seek out couple's counselling once he returns from Ste. Anne's."	
May 30, 2016	Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette accompanies Lionel Desmond to the airport prior to his departure for in-patient treatment at Ste. Anne's Hospital, Quebec. Lionel Desmond continues to vent his frustrations about Shanna Desmond. It is clear that marital breakdown remains a heavy burden for him as he enters the beginning stages of the in-patient program. Ms. Doucette's progress note reads: *"He was talkative and looking forward to the time he will spend in Ste-Anne-de-Bellevue, however remains upset about the status of his marital relationship. He and his spouse are not getting along and he feels she is playing mind games with him. Veteran was unexpectedly able to have some time with his daughter yesterday."* It is impossible to ignore the frequency and consistency to which Lionel Desmond refers to his marital breakdown and the impact it is having on him when he communicates with Veterans Affairs Canada (VAC). Between his May 25, 2015, Transition Interview and his admission to Ste. Anne's, Lionel Desmond is documented as having interacted with his case manager or someone from Veterans Affairs Canada (VAC) on 17 occasions. On 12 of those 17 interactions, he is documented as having conveyed concerns about his marital relationship and the stress/impact it is having on him.	Exhibit P-000117 [page 13]
May 30, 2016	Lionel Desmond is admitted to the Operational Stress Injuries Clinic at Sainte-Anne de-Bellevue (Quebec). Specifically, he is admitted to the Stabilization Program in the Residential Treatment Clinic for Operational Stress Injuries (RTCOSI). He is under the care of Psychiatrist Dr. Robert Ouellette during the initial stabilization phase.	Exhibit P-000254 [page 268]
May 31, 2016	An initial "Nursing Data Collection" and "MENTAL STATUS EXAM" is completed upon admission to Ste. Anne's. Several notable highlights from Lionel Desmond's initial intake include: 1. "Past suicide attempt ☐ no ☒ Yes	Exhibit P-000254 [page 85]

	4 - 5 years ago shotgun" 2. Lionel Desmond's "THOUGHT CONTENT" is "☒ Invaded by daily living situations, financial concerns, unemployment, children, relationship issues:" 3. His relationship with Shanna Desmond and family is described as "Tense." 4. Lionel Desmond lists "war + action movies," "arguing c̄ wife" [emphasis added] under the heading "Are there things in particular that would incite you to react strongly?" 5. Lionel Desmond answers "Yes" to the following: a. *"My relationship with my spouse is very difficult right now."* *b. "I'm experiencing strained relationships within my family."* *c. "My relationships with my friends are frustrating and deceiving."*	 [page 82] [page 84] [page 90] [page 89]
May 31, 2016	Treating Psychiatrist Dr. Robert Ouellette completes an initial psychiatric assessment of Lionel Desmond. The principal diagnosis is as follows: *"1. PTSD of severe chronic intensity, linked to a mission in Afghanistan in 2007.* *2. Chronic major depression related to PTSD.* *3. Alcohol abuse/ dependence in recent remission.* *4. Traits of mixed personality."* Other diagnosis and problems: *"Mental and behavioral disorders due to use of alcohol, dependence syndrome* *Low back pain* *Tinnitus*	Exhibit P-000254 [pages 15 – 16]

	Severe depressive episode without psychotic symptoms *Mixed personality disorders and other personality disorder* *Paranoid personality* *Anxiety disorder, unspecified"*	
	With respect to Mr. Desmond's alcohol and marijuana consumption, the following notation is made: *"**Alcohol:** until a month ago, the gentleman could drink a dozen beers a day, several times a week. He has stopped drinking alcohol now. His alcohol consumption had increased significantly after his mission to Afghanistan in 2007."* *"He claims to have been prescribed marijuana for his chronic pain and anxiety. The marijuana increased his anxiety, he says, so he stopped smoking it."*	Exhibit P-000254 [pages 42 – 43]
	After his initial meeting with Lionel Desmond, Psychiatrist Dr. Robert Ouellette reports the following: *"In the house, the gentleman therefore developed a lot of irritability with his family. This is the reason for the couple's separation and near-break-up. The spouse of the gentleman* [Shanna Desmond] *reportedly called the police a few times because of irritability. No legal consequences has taken place. The gentleman feels great sadness at the loss of confidence in his family. He hopes that the current treatments will improve his relationship. He doesn't want to part with his little girl. He would have had suicidal thoughts before, but he got rid of his guns at home, and he says he no longer has any suicidal thoughts now."*	Exhibit P-000254 [page 44]
	Dr. Ouellette also takes note of Mr. Desmond's sleep disturbances and marital breakdown: *"He experienced separation from his family because of irritability and anxiety."*	Exhibit P-000254 [page 41]
		Exhibit P-000254

	"As soon as he returned from his mission, the gentleman started having nightmares. Currently, he says he has nightmares almost every night. He dreams of homicides. Sometimes he begins to have dreams that are "good". Subsequently, his dreams degenerate into nightmares. *The gentleman wakes up often at night in a state of stress, in a state of sweating. In the morning he feels exhausted and tired. The gentleman says he tried to take Prazosin for nightmares. He developed palpitations, he says, with this medication. He also took Zopiclone, but he did not like the effect of this medication. At bedtime, the gentleman feels anxious. He checks the doors of the house. He tends to isolate himself more and more at home. During his days, the gentleman therefore feels tired. He easily feels anxious to leave the house and go to public places."*	[page 43]
	After this initial assessment Dr. Ouellette outlines the following treatment plan: *"He has side effects to most of the drugs given. Since it continues to be very symptomatic, he is referred to the Stabilization Program and Residential Program for an in-depth assessment and for medication adjustments.* *In addition, the gentleman is socially isolated and treatment at the psychosocial level appears important in his case."*	Exhibit P-000254 [pages 41 – 42]
	"▪ we admit Mr. Desmond to the stabilization department of Sainte-Anne Hospital. *▪ possibly, the gentleman may be admitted to the Residential Department for social rehabilitation.* *▪ in the stabilization department, the treatment will focus mainly on sleep problems and nightmares, initially.* *▪ possibly treatment for daytime anxiety and depression will also be addressed.* *The gentleman agrees with the treatment plan."*	Exhibit P-000254 [page 45]
	Lionel Desmond's anger, frustration, and resentment towards Shanna Desmond persists throughout the entirety of his stay at Ste. Anne's. He is totally fixated on the collapse of his marriage and the strain this has put on the relationships with his daughter and family.	Exhibit P-000254 [page 302]

	Consistent with Dr. Ouellette's observations, Mr. Desmond makes many similar disclosures to his Ste. Anne's treatment team. Examples are documented by Psychologist/Clinical Coordinator Dr. Isabelle Gagnon, Social Worker Kama Hamilton, Psychoeducator Marie-Ève Royer, and Therapist Maria Riccardi. *"The client initially identifies his marital relationship as the main source of distress …"* Psychologist Dr. Isabelle Gagnon	
	"Mr. Desmond has been married for 10 years but has been living seperately [*sic*] *from his wife for 7 years. He is unable to specify how often he sees his wife and his 9 year old daughter. When asked if his wife and child visit him he responds that once a year she comes to see him but that sometimes he is not at home when she comes. Writer asked if there are any planned visits and again he is unable to respond. He later states that sometimes they see eachother* [*sic*] *for Christmas, but that if the weather is bad, he tells them to stay home. It is unclear how much, if any, contact he has had with his wife and child for the past 7 years."* Social Worker Kama Hamilton	Exhibit P-000254 [page 241]
	"He identifies his relationship with his wife as his current concern. He explains that he has been telling her he is committed to the relationship but that he has not received any information from her regarding this commitment. The client says he intends to confront his wife and that if she does not profess her love for him, it will mean she has been taking advantage of him for financial reasons. Mr. Desmond states that he does not want to think about the past at all, because this would prompt flashbacks. He assures us [the psychologist] *he would not hurt his wife and would simply cut ties with her, but that he thinks she is afraid of him. The client* [Lionel Desmond] *also shares his belief that this separation would be a setback for him."* *"**Observations:** The client* [*sic*] *speech is repetitive, rushed and aggressive. He frequently swears and has poor eye contact."* Psychologist Dr. Isabelle Gagnon	Exhibit P-000254 [page 289]

	"He also indicates being preoccupied with his conjugal and familial status. He details the difficulties in his marriage and the effect they have on his daughter. He recount [*sic*] *a moment when he was having an argument with his wife and ended the conversation by text with the word Goodbye, apparently prompting her to notify the police of his suicidal intentions."* Psychologist Dr. Isabelle Gagnon	Exhibit P-000254 [page 275]
	"We then encourage the client to recognise his own patterns of interactions, namely his verbal altercations (raised voice, use of swear words, fast rhythm of speech, interruptions of others) in moments of high emotional arousal. The impact of these interactions is also highlighted and the client reports his wife would have indicated she will end the relationship if Mr. Desmond does not complete the program." Psychologist Dr. Isabelle Gagnon	Exhibit P-000254 [page 286]
	"The client states he would like to be able to better express his needs in his romantic relationship and to reduce the frequency of aggressive thoughts. Mr. Desmond states that loud noises, particularly yelling in the context of an argument brings about intense auditory flashbacks." Psychologist Dr. Isabelle Gagnon	Exhibit P-000254 [page 278]
	"When asked about his objectives, Mr Desmond states that he wants to work on his relationship with his wife. Upon further exploration, Mr Desmond identifies the expression of anger and deficits in communication skills as the main obstacles to satisfying social relationships." Psychologist Dr. Isabelle Gagnon	Exhibit P-000254 [page 304]

	"… when we engage the client in discussions regarding neutral or pleasant subjects, such as work-out techniques, the client's speech pattern seems relatively organised. However, when distressing subjects are brought up, such as marital conflicts, the client displays more pronounced tangential speech patterns and provides more evasive answers." Psychologist Dr. Isabelle Gagnon	Exhibit P-000254 [page 303]
	"He stated that sometimes he has the desire to drink, but he says that it's manageable. L.D. was generally calm during our meetings with the exception of moment [*sic*] *when he began talking about his relationship with his wife. At these times, it was difficult for him to calm down and refocus on the main topic of our meeting.* *The main recommendation is that Mr. Desmond should be seen by an addiction counsellor because of his history of substance abuse and because he remains undecided as to his intentions to consume in the future."* Psychoeducator, Marie-Ève Royer	Exhibit P-000254 [pages 272 – 273]
	"Mr. Desmond names his goal of being a better father and husband, but appears to have some difficulty defining what that means for him. He frequently mentions communication as problematic for him in his relationship with his wife but cannot identify specific areas in which this could be improved. He describes feeling easily angered & having some difficulty controlling this. He is sensitive to the importance of maintaining control of his anger particularly in the presence of his daughter and identifies learning anger management skills as a need." Social Worker Kama Hamilton	Exhibit P-000254 [page 238]
	"The client reports that he does not feel able to express needs, particularly when frustration and anger is involved. He states that in the past, he has experienced instances of losing control and being "a loose cannon" and now he prefers to isolate himself." Psychologist Dr. Isabelle Gagnon	Exhibit P-000254 [page 279]

	"He also says that taking cannabis, and communicating with his wife through the use of Facebook or texts tend to lead him to feel worst [*sic*]*."* Psychologist Dr. Isabelle Gagnon	Exhibit P-000254 [page 275]
	"He states that in the past he has come home from a stressful day at work and expressed anger towards his family." Psychologist Dr. Isabelle Gagnon	Exhibit P-000254 [page 285]
	*"__**Objectives named by client:**__* *…* *3) Improve communication and trust with the aim of strengthening his relationships with his wife and daughter."* Social Worker Kama Hamilton	Exhibit P-000254 [page 268]
	"Relationships with family are strained according to Mr. Desmond." Social Worker Kama Hamilton	Exhibit P-000254 [page 249]
	"The writer brought Mr. Desmond back to the conditions his wife has set for their potential reunion. Her last condition was that she be allowed to take over the payment of bills. He states that she was quite good at this but that when he took over he felt overwhelmed and was unable to stay on top of finances. This last information regarding the finances appears to be in direct contrast with previous information wherein Mr. Desmond stated that his wife spent all the money from the account and that he was left with very little to pay bills." Social Worker Kama Hamilton	Exhibit P-000254 [page 246]
	"Mr. Desmond is currently receiveing [sic] *a disability pension. He describes a difficult and strained financial situation, stating that he paid for his wife to return to school for her nursing degree, that he shares a bank account with her from which she draws money. He is left with very little money at the end of the month, often not enough*	Exhibit P-000254 [page 242]

	to pay his bills. Again, it is difficult to obtain precise information on this subject, but the impression is that he is at risk of losing his home (foreclosure) due to not paying the mortgage." Social Worker Kama Hamilton	
	"Impressions: Mr. Desmond often appears to contradict himself regarding details of events. Sometimes he seems to be saying that his wife is dishonest and can't be trusted, taking advantage of him financially, and other times he admits that she was doing a good job with the finances, and that when she cosigned his name for a loan, in fact she did it because she was not aware that he had cancelled her power of attorney. It continues to be difficult to get accurate and clear information from Mr. Desmond." Social Worker Kama Hamilton	Exhibit P-000254 [page 247]
	"He worked on a new image representing his daughter. At the end of the session, he was not satisfied with the result and tarred the image. He said that he would like to develop his self-esteem and to spend more time with his daughter. He portrayed symptoms of impulsivity and reported that he has intrusive thoughts." Therapist Maria Riccardi	Exhibit P-000254 [page 358]
	"He worked in silence. He continued an image representing his daughter using wood burning tools. He reported that he would like to reinforce a sense of safety at the centre and in his home environment. He discloded [*sic*] *to the art therapist that he felt tense and worried. He reported that he has intrusive thoughts that interfeer* [*sic*] *with his ability to concentrate."* Therapist Maria Riccardi	Exhibit P-000254 [page 359]
	"He discussed having difficulty to participate in the present moment due to intrusive thoughts related to his home environment. He expressed that he feels tensed [*sic*] *and he has difficult* [*sic*] *to tolerate the distress of others. … He made the portrait* of *his wife*." Therapist Maria Riccardi	Exhibit P-000254 [page 361]

	Like initially identified by Dr. Ouellette, Lionel Desmond over the course of his time at Ste. Anne's disclosed to other professionals that he was having a difficult time focusing and sleeping. He reported having frequent dreams of causing physical harm to Shanna Desmond: *"Mr. Desmond indicates having sleeping difficulties, partly due to recurring nightmares of finding his wife cheating on him and of attacking her and her lover. When questionned* [*sic*] *on symptoms related to trauma events, the client states that he cannot think of the past and refuses to elaborate*." Psychologist Dr. Isabelle Gagnon	Exhibit P-000254 [page 302]
	"Recurring nightmare in which he believes that his wife is having an affair and he enters her house and "chops her to pieces", ++++blood, graphic." Social Worker Kama Hamilton	Exhibit P-000255 [page 3]
	"He describes incidents in which he was yelling at his wife and felt out of control. When questioned about the possibility of attacking someone, the client denies any worry on the matter." Psychologist Dr. Isabelle Gagnon	Exhibit P-000254 [page 282]
June 10, 2016	Two (2) weeks into the Ste. Anne's program Lionel Desmond has a phone conversation with Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette. He updates her on his progress and for the first time expresses that he would like Veterans Affairs Canada (VAC) to consider covering the cost of having Shanna and Aaliyah visit him at the hospital. Highlights from Ms. Doucette's progress notes include: a. *"He spoke highly of the place and the beauty of the town in which it is located."* b. "*Discussed the possibility of his wife visiting. He said he is still unsure about this as communication is still a challenge for them, but he thought he would ask. CM indicated she is unaware, at this time, of any funds to pay for family's travel*	Exhibit P-000117 [page 12]

	to visit, unless of course it is considered to be part of/a requirement of his treatment. Agreed veteran would find out more on his end as would CM." c. *"Overall, veteran presented in a much calmer state than he has over the phone in prior weeks. CM commended him on taking treatment and wellness seriously."*	
June 14, 2016	During his second last meeting with Lionel Desmond, Dr. Ouellette makes an adjustment to the initial May 31, 2016, diagnosis. Lionel Desmond begins to show improvement in several areas. He is noted as having improved sleep along with reductions in PTSD symptoms, anxiety, depression, and alcohol dependence. Despite the improvement Dr. Ouellette's evidence is that Lionel Desmond is never fully stabilized. Even with his continued instability Lionel Desmond proceeds forward to the residential phase rather than being kept at stabilization. Mr. Desmond continues to refuse Dr. Ouellette's recommendations that he take various prescribed medications. He still actively exhibits social struggles in his interactions with others. He continues to need stabilization with respect to anger management and marital difficulties. Deep issues of trust and paranoia continue to exist with respect to his wife and others. Dr. Ouellette feels that certain medications, had he accepted them, would be of assistance in stabilizing emotional deregulation, anxiety, and irritability. In Dr. Ouellette's opinion these medications are "essential" to full stabilization. However, Lionel Desmond refuses to take them consistently, if at all. When Lionel Desmond moved to the residential phase Dr. Ouellette had hoped he would eventually become compliant with medication. This never happened.	Transcript March 2, 2021
	The diagnosis heading into the stabilization portion of the Ste. Anne's program now reads: *"1. PTSD of mild to moderate intensity.* *2. Major depression in remission.* *3. Alcohol abuse and dependence in recent remission.* *4. Traits of mixed personality."* The following medications are prescribed:	Exhibit P-000254 [pages 48 – 49]

		1) Topamax 25 mg An anticonvulsant drug found effective in reducing PTSD symptoms and emotional deregulation. 2) Sublinox 10 mg A sedative-hypnotic drug used to facilitate sleep. 3) Prazosin 2 mg Traditionally, a blood pressure medication, however, found effective in reducing nightmares. 4) Seroquel XR A long release anti-psychotic used to assist in reducing anxiety and depression. 5) Seroquel 25 mg An anti-psychotic used to assist in reducing anxiety. Lionel Desmond is noted as having a history of self-reported side effects to most prescribed medications. Dr. Ouellette is aware of Mr. Desmond's historical refusal to comply with medications. In terms of the drugs prescribed by Dr. Ouellette, Lionel Desmond takes Topamax for one (1) night and refuses to take it again. He also refuses to continue with Seroquel.	
June 14,	**2016**	**<u>Phone Contact New Brunswick OSI</u>** Lionel Desmond calls from Ste. Anne's to update Dr. Murgatroyd. The following notes are made by Dr. Murgatroyd: *"He indicated things are going well in his program. He is currently in stabilization."* *"Given the positive steps he is taking in his life, Mr. Desmond stated he is very motivated to also work on his relationship. With this said, he feels his wife needs to be involved in, and informed about, his treatment. Therefore, he gave his verbal consent to the writer that*	Exhibit P-000244 [page 47]

		the OSI Clinic can exchange information with his wife. He provided her cell number, which the writer will add to his file."	
June 16, 2016		Lionel Desmond again calls Veterans Affairs Canada (VAC) from the hospital in Ste. Anne's. He is requesting that Veterans Affairs Canada (VAC) cover Shanna and Aaliyah's travel costs for a hospital visit between June 23, 2016, and June 26, 2016.	Exhibit P-000273 [page 11]
June 17, 2016		Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette returns Lionel Desmond's call from June 16, 2016. He continues to struggle with medication compliance and feels strongly about Veterans Affairs Canada (VAC) funding the travel costs of Shanna and Aaliyah's visit to the Quebec Hospital. He continues to have anxiety/stress about the sale of his New Brunswick home and becomes agitated during the phone call. Highlights from Ms. Doucette's progress notes include: a. *"He reported doing okay in the stabilization program, other than having had a panic attack one night this week. He said he feels the medication are* [*sic*] *responsible for this, he has spoken to staff about this."* b. *"Discussed payment for spouse to visit, CM expressed she has not* [*sic*] *basis on which to approve this request."* *c. "Veteran also talked about his house for sale and the stress that is causing him. CM tried to encourage him to stay focused on what he can control, but veteran was evidently too agitated to be talking about coping strategies or to reason. He eventually apologized, stating he could not continue to talk, and abruptly ended the call. CM reached out to hospital staff via phone, to see if MH staff would check in with him, but was told all people in his unit had left for the weekend. CM thus called veteran back and left a voicemail message to validate his frustrations, to say she regrest* [*sic*] *the call did not go well for him, and that she will remain available to talk to him in the days/weeks to come when he feels better."*	Exhibit P-000117 [pages 11 – 12]
June 20, 2016		Lionel Desmond expresses concerns about his relationship with Veterans Affairs Canada (VAC). He expresses this concern to a	Exhibit P-000254 [page 134]

	member of the Ste. Anne's nursing staff. The nursing note reads as follows: *"Met $\bar{c}$ pt in am for evaluation. Pt expressed his frustration $\bar{c}$ case manager. His action plan is to call V.A.C to see whether his wife's stay in montreal* [*sic*] *will be funded/reimbursed & to request a new case manager. States he is unable to work $\bar{c}$ the present one & that she triggers his anger. Pt rates his feeling of anger 7/10 ..."*	
	Mr. Desmond also shares this frustration with Clinical Psychologist Dr. Isabelle Gagnon: *"When Mr. Desmond expresses anger at feeling abandoned by his case worker and VAC, we heighten the underlying primary emotion of sadness and thoughts of being abandoned*."	Exhibit P-000254 [page 279]
	In addition, Dr. Gagnon makes several observations regarding Lionel Desmond's fixation on external stressors, preoccupation with racing thoughts, impulsiveness, avoidance, and inability to control his anger. *"When Mr. Desmond arrives late for the session, avoidance is explored. He denies feeling any discomfort during the sessions but reports feeling unable to focus because of racing thoughts concerning external stressors. The client's tangential thought pattern is reflected. Mr. Desmond indicates that he is aware of his racing thoughts and that he feels trapped in a cycle of thoughts when an external event preoccupies him. … The client reports that he does not feel able to express needs, particularly when frustration and anger is involved. He states that in the past, he has experienced instances of losing control and being "a loose cannon" and now he prefers to isolate himself. The term loose cannon is explored and a risk assessment for violence is conducted. The client affirms he has no violent intentions towards any individual at this time. When questioned about losing control, he specifies that he worries about raising his voice and not being able to function effectively. Risk factors are assessed. The client identifies a few instances of impulsive actions, such as driving under the influence of alcohol ..."*	Exhibit P-000254 [page 279]
June 20, 2016	For a third time in five (5) days Lionel Desmond calls Veterans Affairs Canada (VAC) from the Ste. Anne's Hospital, Quebec. He continues	Exhibit P-000117 [pages 12 – 13]

	to stress the importance of having Shanna and Aaliyah visit him in person. He urges Veterans Affairs Canada (VAC) to cover their associated travel costs. The progress note reads: *"Vetearn [sic] feels that it would be helpful to see his family as he is finding it difficult being away from them. His wife and daughter want to drive to Montreal. Veteran said he has had difficulties with his family in the past but wants to be able to move forward with his wife and look towards their future together."* A further entry from the same date reads: *"Client is most anxious for a decision re the request for his wife and child to visit him at Ste Anne's. Advised decision to be given to him as soon as it is rendered ..."* Despite his efforts, Veterans Affairs Canada (VAC) ultimately declines to cover Shanna and Aaliyah's travel expenses. The Veterans Affairs Canada (VAC) database entry from this date reads: *"HRT for family to visit Veteran at Saint Anne's hospital is not approved at this time. No psycho-educational component to visit identified."* Interestingly, this appears to be in contrast to an earlier note from the same day where Veterans Affairs Canada (VAC) spoke with Ste. Anne's Social Worker Kama Hamilton. Although Ms. Hamilton noted that the Ste. Anne's program does not have a program specifically outlined for family, such a visit "may benefit the veteran's psychosocial wellbeing as he moves forward in rehab."	Exhibit P-000273 [page 10]
June 21, 2016	Despite the prominent impact marital breakdown and domestic stressors appear to be having on Lionel Desmond's clinical portrait, there appears to be a lack of priority given to them. At a minimum, not meeting with Shanna Desmond during her visit to Quebec is a missed opportunity. Rigidity, policy, scheduling, and staffing shortages led to a lost opportunity in gaining Shanna Desmond's perspective. Shanna Desmond is going to Quebec to visit Lionel Desmond while he is at the Ste. Anne's Hospital. Her perspective is paramount. Lionel Desmond has repeatedly expressed concerns about the state of their relationship and his eagerness to repair it. These three (3) factors should seemingly prompt a desire to obtain his consent and	Exhibit P-000117 [page 12]

	involve her in the early stages of the rehabilitation process. However, the Veterans Affairs Canada (VAC) progress notes from this date read: *a.* "*T/C* [telephone call] *with SW* [social worker] *at Saint Anne's stabilization unit, Kama Hamilton. Hospital staff are aware of the Veteran wanting his family to visit and Veteran has been very preoccupied by his want to see his family. Staff are unable to say from a clinical perspective if this would be helpful or not for the Veteran in terms of his treatment. Staff are unsure of the purpose of the visit and what the contact has been like between Veteran and his wife since his arrival. Staff are unable to offer any psycho-educational component to the visit as it is a long weekend and there would not be staff available while Veteran's wife is there. Kama said that it is normal for Veteran's* [*sic*] *who live close to be able to go home on the weekend and be able to practice their skills with their family but this is not possible for the Veteran due to distance."* b. "*The hospital is unable to offer any psycho-educational component at this time due to a holiday and staff is unable to say whether the visit would be beneficial for Veteran's treatment. CM unable to approve HRT at this time."* c. "*CM explained that if there was going to be an educational component for his family as part of his treatment plan at Saint Anne's during his time there then HRT for his family could be looked at again. Veteran was frustrated by this as he was under the impression that travel had been approved on June 17, 2016. Veteran requested contact by a manager about his concerns.*" A further Veterans Affairs Canada (VAC) database entry reads: "*Spoke to social worker Kama, and NurseTheresa* [*sic*], *who both stated that next-of-kin visit is welcomed.* [*sic*] *though not required. There is no program outlined for the family, it is merely a visit that may benefit the veteran's psychosocial wellbeing as he moves forward in rehab."*	 Exhibit P-000273 [page 10]
June 22, 2016	Mr. Desmond expresses various concerns to Clinical Psychologist Isabelle Gagnon about his medications and times where he "felt out of control" in relation to Shanna Desmond.	Exhibit P-000254 [page 282]

	"The aim of this meeting is to adress [*sic*] *recent concerns from Dr. Ouellette about potential for violence and reticence about changing medication in order to better orient further treatment and to discuss the pertinence of an eventual transfer to the residential program."* *"When asked about his feelings of anger, M. Desmond recognises that he has felt out of control. He describes incidents in which he was yelling at his wife and felt out of control. When questioned about the possibility of attacking someone, the client denies any worry on the matter."* *"He expresses a significant amount of distrust and fear for the potential side-effects of medication."*	
	Lionel Desmond also expresses significant distrust and fear for the potential side effects of medication. *"The client's reticence towards changing his medication is brought up, and the treatment team explains that this may limit certain avenues of change. The client states that he would rather take a smaller amount of medication and would like to try to effect change through other means. He expresses a significant amount of distrust and fear for the potential side-effects of medication."*	Exhibit P-000254 [page 282]
June 23 and 24, 2016	Shanna Desmond and Aaliyah Desmond travel to Quebec. They visit Lionel Desmond at the Ste. Anne's Clinic.	Exhibit P-000254 [page 246]
June 24, 2016	Lionel Desmond is upset with the Veterans Affairs Canada (VAC) decision to not cover the cost of the Quebec travel for Shanna and Aaliyah Desmond. On this date, Lionel Desmond calls Veterans Affairs Canada (VAC) from Ste. Anne's Hospital. He is upset. He is requesting that he be assigned a new Veterans Affairs Canada (VAC) case manager. The Veterans Affairs Canada (VAC) database entry from this date reads: "*Based on consult with active CM, VSTM will not contact with* [*sic*] *Veteran as he is currently in patient and CM feels that a follow up contact would be appropriate to determine if engagement has been severed and VSTM needs to validate and consider reassignment."* At the Inquiry, Ms. Doucette testified:	Exhibit P-000273 [page 10]

	a. *"Obviously, one of the things that really stands out from the notes in June is his wish to have his wife and daughter visit."* b. *"I think he spoke to two different intake case managers while I was away. And when the request was denied, he was quite upset about that."* c. *"… the VSTM team manager who contacted me and said, Well, here's the thing. We have a veteran who is requesting a new case manager."* *d. "So there was a few weeks that had passed and, as you mentioned, that his wife and daughter did end up visiting at their own expense, regardless. So . . . and when I talked to him in July, he seemed to be in a better space. And I got an update from him and then, you know, mentioned to him, I realize that you spoke to a manager and I am not at all upset about that. I just wanted to let you know that I've been made aware and wanted to see what you want to do about this.* *And he was immediately apologetic and I don't even know if he had said any things bad about me. Like that didn't make it back to me. But I just said, It's fine. I'm willing to continue working with you. I don't think the working relationship is completely ruptured but that is up to you and then he confirmed that he was okay to continue as-is."*	Transcript June 22, 2021 [page 131] Transcript June 22, 2021 [page 132] Transcript June 22, 2021 [pages 132- 133] Transcript June 22, 2021 [pages 133 – 134]
June 27, 2016	Despite his continued instability Lionel Desmond continues to express to nursing staff his desire to leave the stabilization phase and be moved to the residential portion of the program. He also continues to resist recommendations that he take various prescribed medications: *"States Stabilisation program is boring. Wants to keep busy by being in groups to learn how to manage emotions and manage anger. States "need to keep brain busy". Reports Seroquel is making him gain weight and afraid to have diabetes as it is something that runs in his family. Writer explained that all meds have side effects."* *"Encouraged pt to discuss with his psychiatrist."*	Exhibit P-000254 [pages 142 - 143]

June 28, 2016	At the conclusion of the stabilization phase, Dr. Ouellette's final diagnosis is: *"1. Severe, chronic and complex PTSD linked to a mission in Afghanistan in 2007.* *2. Major depression related to PTSD.* *3. Mixed personality traits including paranoid personality traits.* *4. Alcohol abuse and dependence in recent remission."*	Exhibit P-000254 [page 17]
June 28, 2016	Mr. Desmond advises Dr. Isabelle Gagnon that he feels like leaving the Ste. Anne's program. He also shares pressures of finding employment, feeling like an "outsider," and being "rejected by his peers." *"M. Desmond states he felt tempted to leave the program, but that his wife encouraged him to stay. When questioned about his motives for leaving, the client explains he feels pressure to find a new job."* *"He describes himself as a quiet child, as feeling rejected by his peers and as having had to become self-reliant early on in the context of a single-parent family. He then reflects that his mode of communication changed drastically when he entered the army and from being quiet about his needs, he started using shouting and obscenities. M. Desmond describes his experience in the military world as being difficult and his feeling of being an outsider."*	Exhibit P-000254 [page 281]
June 29, 2016	Social Worker Kama Hamilton meets with Lionel Desmond days after the Shanna Desmond visit. Ms. Hamilton reports the following: *"Mr. Desmond's plan for after his discharge from CTRTSO is to sell his house in New Brunswick and to re-locate to a place in the countryside near his wife (in Nova Scotia). He states that the* [redacted] *seems to be taking a long time to sell the house, and that he has already twice reduced the price. He would like to get away from New Brunswick as it is a military town and full of triggors* [sic] *for him. He would also like to be closer to his wife and daughter."*	Exhibit P-000254 [page 246]
	"When asked how his weekend was, Mr. Desmond says (repeatedly) that "it was hard". He talks about having to say goodbye to his wife and child, but when asked how the visit actually went he appears to	Exhibit P-000254 [page 246]

	have difficulty responding. Writer asked what he wants for his relationship and he responds that he would like to renew his vows and that he mentionned [*sic*] *this to his wife. The writer then tried several times to ask what his wife's response was to this question. After having to bring back Mr. Desmond to the question at least 3 times he finally informed the writer that his wife agreed to this under certain conditions. She asked that he apologize to her and to her parents on facebook (for having written insulting things about them in the past). Mr. Desmond admits that he wrote unkind things about both his wife and Secondly she requested that he "tell the truth" to the doctor about the fact that he has shared his medication with ."*	
	"The writer brought Mr. Desmond back to the conditions his wife has set for their potential reunion. Her last condition was that she be allowed to take over the payment of bills. He states that she was quite good at this but that when he took over he felt overwhelmed and was unable to stay on top of finances. This last information regarding the finances appears to be in direct contrast with previous information wherein Mr. Desmond stated that his wife spent all the money from the account and that he was left with very little to pay bills."	Exhibit P-000254 [page 246]
	"Mr. Desmond also appeared to be unable to describe what the visit with his daughter was like. He does mention that she was playing games on a device most of the time, but is unable to elablorate [*sic*] *on whether or not they had a chance to talk (he says he was very tired when they arrived late on thursday* [*sic*] *night (midnight) and says that during their visit with family in Montreal he did not say a word."*	Exhibit P-000254 [page 246]
	At this point both Dr. Ouellette and Social Worker Kama Hamilton feel it necessary to initiate direct contact with Shanna Desmond. This appears motivated by Lionel Desmond's continued and persistent focus on the struggles within his marriage. The marital discord is noted in frequent observable anger, frustration, and resentment directed towards Shanna Desmond. The following key notation is made by Social Worker Kama Hamilton: *"Follow up: will contact Mrs. Shanna Desmond (as requested by Dr. Ouellette) with aim of discovering a more complete picture of Mr. Desmond's situation and to help determine any risk of **dangerosity**."* [Emphasis added]	Exhibit P-000254 [page 247]

June 29,	**2016**	Dr. Murgatroyd speaks with Ste. Anne's Social Worker Kama Hamilton. The Ste. Anne's team has expressed concern about Mr. Desmond's "dangerosity level." It is this concern which forms the basis for the call. The following note is made by Dr. Murgatroyd: *"She informed the writer that he had had a slight outburst during a meeting with the psychiatrist. She asked the writer if the writer had seen Mr. Desmond react this way in the past. Following this incident she said that they assessed his dangerosity level, which was low. Other than this outburst, things seem to be going well. She also said that they had been in contact with Mr. Desmond's partner, which was helpful for them."*	Exhibit P-000244 [page 46]
June 30, 2016		After obtaining written authorization from Lionel Desmond, Social Worker Kama Hamilton contacts Shanna Desmond by telephone. The purpose of the call is to "obtain a more complete picture of his current situation, antecedents of violent behaviour, and any other information pertinent to the intervention plan." Kama Hamilton notes that Shanna Desmond had a "great deal to tell" her including the following: *"Mrs. Desmond had a great deal to tell the writer. She explained that since Mr. Desmond had taken her off the list of people he had authorized his external team to speak to she had been unable to communicate her concerns with them.* *According to his wife, Mr. Desmond behaves like a "completely different person" since his time on his missions. All of the following incidents and observations have occurred since his return. Mr. Desmond and his wife began dating in highschool, and she states that at that time he was happy, active in school & had many friends."* ***"****** *also to note that her daughter is frightened when he yells, but that he has never been physically violent towards either of them and she has never felt that he would hurt them."* *"1. Anger issues: many triggers, don't know what they are, therefore unpredictable angry episodes, impossible not to trigger him. Unpredictable. Won't let daughter stay alone with him. Ex: when daughter hit the car with the four wheeler, she was afraid to tell him but he was not angry, said its* [sic] *ok as long as she wasn't*	Exhibit P-000255 [pages 1 - 4]

	hurt, but when she spilled water on the floor he flew into (quick escalation) a rage (hollering, yelling) *2. Anger: violence: 2 incidents of violence against objects: a) throwing drawers around his room (they don't know why, he went to work and came back in a different mood)* *…* *4. Becomes obsessed with a small slight, will talk only about one thing for months, can be distracted for a few minutes but then right back to obsession. If you call him to discuss he feels this is intrusive if you don't call it is neglect.* *5. Suicide risk: texting things like: Tell daughter that I'll be watching her from above, that I won't be in this world but I'll always love her…later denies that he made any insinuation.* *6. Obsessive texting: ex. She checked texts in morning, then 2-3 hours later on her break there were 83 messages. Another time he was texting through the night, she woke up to over 400 texts (many nasty) texting at least one per minute sometimes 2 per minute. She suggests that we ask to see his phone to look at what he wrote and time line* *7. Meds: she has suggested to him that she thinks he may have bipolar disorder: he becomes defensive, when he discovered that the med he had been prescribed was used for bipolar disorder became angry and stopped taking it: MOOD STABILISER, will often stop taking meds, looking for reasons to stop (ex this past weekend was saying that the meds stopped him from remembering his dreams, which is "not normal" therefore wonders if he should stop)* *…* *9. OCD washing gun obsessively, but never been used."* *"Obsessive behaviour: unable to stop thinking and talking about an incident, Impulsive/compulsive behaviour in his purchases and then giving things away."* *"10. Flashback: car: was very hot outside, she was getting ready inside, he became very angry, hit the top of the car (frame) made a big fist print screaming:,"hot hot hot"!! then began crying, went to*	

	basement, lay on floor naked to cool down (flashback to Afghanistan, later he explained that he felt like he was trapped in Afghanistan *…* *13. Financial stress: large burden while she was in school, but that she managed all the bills, until one day after his return he received a statement from Citi-financial saying what is owed (one month in advance) and he thought he was behind. He emptied his account, opened a new account, paid off the entire bill, which meant he had nothing left in order to pay his other bills. Although she tried to explain that she was paying the bills he didn't believe her. Another bill he paid three months payment at once, but didn't realize that the interest was still accumulating on the balance, so owed $1600 in interest. Went to insurance, it was explained, he said he understood, joking, laughing, then in car on the way home he immediately accused her of not paying bills."* *"3. She thinks he has "manic episodes": impulsiveness, buys $4000 snow blower for a tiny front driveway, $3000 power saw, then will sell/give everything away (she thinks either because he regrets what he did, or in anger against her)"* *"Ms. Desmond also discussed having difficulty with the rigidity of Mr. Desmond's thinking patterns. … She needed access to the shed but did not have the key. Mr. Desmond became very insistent that she not cut the lock, as it was a $40 lock. Even when she explained that the contents of the shed were far more valuable than the lock, he was unable to accept that she cut it. He eventually sent her the key to the lock."* *"15. Other impulsive behaviour, has called realtor telling her to take house off the market because he's going to go bankrupt and go live in the woods.* *16. Recurring nightmare in which he believes that his wife is having an affair and he enters her house and "chops her to pieces", ++++blood, graphic."* *"12. She has no contact with his team so they hear: what he can remember and what his current obsession is"* [*sic*]. *He took her off the authorized to communicate list."*	

	"Impressions: Mr. Desmond's wife comes across as being a credible source of information. She seems to be genuinely concerned for his well-being. From the information provided certain behaviour patterns appear to be present: paranoid behaviour (mainly regarding his wife's management of finances and her fidelity)"	
June 30, 2016	Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette speaks with Ste. Anne's Social Worker Kama Hamilton. Ms. Hamilton advises that there have been a number of concerning observations made of Lionel Desmond during the first month of the program. These concerns include anger directed towards staff and difficulty getting information from him. Despite having an under-appreciation for the value of Shanna Desmond's perspective and how it could factor into Lionel Desmond's psychosocial rehabilitation, they now wish to speak to her. Contact is made with Shanna Desmond for the first time with the intention of gathering insight into his anger. In addition, a need for additional neurocognitive testing is discussed with Veterans Affairs Canada (VAC) for the first time. Ms. Doucette's June 30, 2016, progress note reads: *a. "Discussed strengths and challenges observed in veteran. In particular, there has been a struggle getting straight answers from him. SW has contacted his wife (who has finally visited him at her own expense) who she thinks provided some reasonable insight into some anger staff have witnessed from him."* *b. "The Ste-Anne's team is discussing if further specialized assessment may be needed in this case. CM advised SW she can contact her to discuss any proposed assessment and she will consider the possibility of adding this (provinding* [*sic*] *coverage) to his rehab plan."* *c. "CM advised SW she is aware veteran is upset with her at the moment; that he expressed this to a colleague. CM plans to let the "dust settle" and try contacting him again to talk thinhs* [*sic*] *out. In the mean time* [*sic*]*, veteran is welcome to call back if he decides he wishes to talk to CM."* The need for timely neuropsychological testing appears to feature prominently during the Ste. Anne's program evaluation. The fact that cognitive deficits may be a factor in Lionel Desmond's lack of responsiveness to treatment underscores the importance of	Exhibit P-000117 [page 11]

	engaging neuropsychological services. Despite the importance being raised as early as June 30, 2016, with Veterans Affairs Canada (VAC), no arrangements are ever made for such testing. Ms. Doucette testified she advised Ste. Anne's Social Worker Kama Hamilton, should such testing be available in Quebec, she would take steps to approve funding. Ms. Doucette believed such testing would have been more easily undertaken in Montreal.	
	a. "Well, it came up in the pre-discharge meeting that they mentioned that a neuropsychological assessment would be part of their final recommendations because of perceived cognitive limitations." *b. "I mean I expressed to Kama Hamilton whatever, you know, specialized assessment you're after, chances are you're surrounded with more professionals than we are."* *c. "I would've gone through the steps to approve it."*	Transcript June 22, 2021 [pages 136 – 137]
	During the Inquiry, Ms. Doucette was asked directly why the neuropsychological testing was never completed before the tragedy of January 3, 2017. Ms. Doucette testified: *a. "Yes, I can explain. And the simplest way I can explain that is there were multiple things that needed to be put into place and services and supports. And there was, based on the first inquiries that I made, no one in my contacts who could identify a psychologist who is specialized because not every psychologist conducts neuropsychological assessments. It's a very specialized field. So there wasn't a provider readily available. We had to go searching for that as we were also trying to set up other services."* *b. "So it was a question of prioritizing what might be most helpful at that moment in the situation we were in. So it wasn't a question of we're ignoring this. It was a question of this is one recommendation among others that we plan to get to. And, unfortunately, it wasn't completed before January."* *c. "That said, I didn't go into an in-depth search of providers in the Halifax area as I was focusing on trying to get other*	Transcript June 22, 2021 [pages 224 – 225]

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services set up. And no disrespect to Mr. Desmond, but he'd also made it clear that he wasn't interested to travel to Halifax to obtain services. So I'm not saying that it wouldn't have happened down the road but there was other things that got prioritized."

During her Inquiry testimony Ms. Doucette was asked several times what efforts she made to locate the resource, which was a healthcare professional who could provide a neuropsychological assessment. She testified that she reached out to several colleagues and despite those efforts none were able to identify a service provider within Nova Scotia. She also testified, despite arranging for such an assessment on another veteran, she could not explain why she did not access the same resource. Finally, she testified:

*"**Q.** Did you do any search . . . Sorry, let me ask, did you do any search? For instance, when you put the term "neuropsychological assessments Nova Scotia" into a search engine, it comes up with a certain number of names and providers. Did you actually do . . . did you go that far to do that?*

***A.** I don't remember doing that. What I'm saying is that I had started searching informally while I was doing other things by asking the contacts around me.*

***Q.** All right, so you never did, for instance, you never went to your computer and went online and put in that as a search term and looked to see what might come up in Nova Scotia for those that provide neuropsychological services.*

***A.** I can't say, no, with certainty. No, I don't think I did."*

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<td>Transcript
June 23, 2021
[pages 318 - 319]</td>
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Lionel Desmond is transferred to the residential phase of the Ste. Anne's program. During this phase Lionel Desmond has 24/7 access to a full medical team who actively collaborate with each other. This team is comprised of:

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<tr><td>1. Nursing Staff</td><td></td></tr>
<tr><td>2. On call Psychiatrist</td><td>Dr. Robert Ouellette and Dr. Dallal</td></tr>
<tr><td>3. Physician</td><td>Dr. Geneviève Richer</td></tr>
<tr><td>4. Clinical Psychologist/ Clinical Coordinator</td><td>Dr. Isabelle Gagnon</td></tr>
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<td>Exhibit P-000254
[pages 268 – 274]</td>
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<tr><td>5. Social Worker</td><td>Kama Hamilton and Hélène Tremblay</td></tr>
<tr><td>6. Occupational Therapist</td><td>Julie Beauchesne</td></tr>
<tr><td>7. Addictions Counsellor and Psychoeducator</td><td>Marie-Ève Royer</td></tr>
<tr><td>8. Recreational Therapist</td><td>Liz Freland</td></tr>
<tr><td>9. Art Therapist</td><td>Maria Riccardi</td></tr>
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It should be noted that Psychiatrist Dr. Robert Ouellette has no further contact with Lionel Desmond after the latter part of June 2016 or during the remainder of his stay at Ste. Anne's. During the entire period of Lionel Desmond's involvement with the residential phase of the program Dr. Ouellette is never consulted. This lack of consultation occurs despite Dr. Ouellette having played a pivotal role in the early stages of Lionel Desmond's diagnosis and treatment. Mr. Desmond's notable struggles, conflicts, and instability continue in the absence of Dr. Ouellette. Having said that Dr. Oullette was clear that he only treated those patients in the stabilization phase.
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<td>July 6, 2016</td>
<td>At various points during his time at Ste. Anne's Lionel Desmond directs anger and aggression towards others. The first documented conflict comes in the form of verbal altercations with other patients both on the unit and while in group therapy sessions. The following notes are made by Dr. Isabelle Gagnon and Social Worker Kama Hamilton:

"Members of the team meet with Mr. Desmond as they have noticed indications of rising tension between M. Desmond and another participant in the program. Mme Julie Beauchesne, Mme Kama Hamilton, Mme Marie-Ève Royer and Dr. Isabelle Gagnon are present. The objectives of this meeting are to help the client maintain respectful interactions with the other participant and to develop tolerance for situations which generate anger. Mr Desmond is agitated through the first part of the session and places the responsibility of his frustration on the other participant. … A common agreement is reached to develop a range of abilities to tolerate and diffuse situations in which the client perceives behaviors he finds unacceptable."</td>
<td>Exhibit P-000254 [page 284]</td>
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<td>"He began to discuss his conflict with another resident on the unit, when writer attempted to focus more on his emotional reaction than on the actions of the other he became increasingly agitated.</td>
<td>Exhibit P-000254 [page 248]</td>
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	Eventually had to request that he stop talking as it was innappropriate [*sic*] *to be discussing another resident who was not in the room but whom everybody knows. Was somewhat difficult for Mr. Desmond to stop and he continued muttering even after writer had firmly asked that he stop and moved on to another group member's example."*	
July 14, 2016	During this session with Dr. Isabelle Gagnon, Mr. Desmond reveals the significant pressures he is under in the general civilian population. He is able to contrast this with how he feels about the more structured environment of the Ste. Anne's Clinic. *"The client indicates he feels he has a low level of control on his internal state in a situation he finds upsetting and he states that this is the way things are because of his PTSD. He states that he finds the environment in the unit helpful because the other participants understand how he feels and ask him for permission before making comments."*	Exhibit P-000254 [page 288]
July 19, 2016	Dr. Isabelle Gagnon has a psychotherapy session with Lionel Desmond. She reports the following: *"He identifies his relationship with his wife as his current concern. He explains that he has been telling her he is committed to the relationship but that he has not received any information from her regarding this commitment. The client says he intends to confront his wife and that if she does not profess her love for him, it will mean she has been taking advantage of him for financial reasons. Mr. Desmond states that he does not want to think about the past at all, because this would prompt flashbacks. He assures us he would not hurt his wife and would simply cut ties with her, but that he thinks she is afraid of him. The client also shares his belief that this separation would be a setback for him."* *"**Observations:** The client* [*sic*] *speech is repetitive, rushed and aggressive. He frequently swears and has poor eye contact."*	Exhibit P-000254 [page 289]
July 26, 2016	In the days prior to his meeting with Social Worker Kama Hamilton, Lionel Desmond has an altercation with a member of the Ste. Anne's nursing staff. Mr. Desmond had gone to the nursing station to request medication. The nurse was unable to locate his medication and requested that he check his room to see if someone had left it	Exhibit P-000254 [pages 258 – 259]

	near his bed. Mr. Desmond became "immediately irritated" and "extremely angry" when asked to check his room several times. In discussing the events with Lionel Desmond, Kama Hamilton notes: *"As Mr. Desmond describes the situation he becomes increasingly agitated (clenched jaw, raised tone, swearing, trembling, finger pointing etc). He had submitted an orange sheet requesting that he change nurses, earlier on this day."* *"Explored with Mr. Desmond the use of the coping card that he developed with Dr. Isabelle Gagnon, to be used at times when he feels angry. It appears that the word coping card acts as a triggor* [*sic*] *for Mr. Desmond as his anger appeared to intensify at the mention. His response to this suggestion was that he didn't need to use it because had the nurse behaved in a different manner he would not have become angry."* *"Mr. Desmond simply repeated (many times) the same statement that the situation was entirely created and provoked by the nurse. He expressed extreme anger in regards to the nurse having called security to be present when he was finally given his medication. He states that he is aware that the individual is afraid of him but states that: "I'm not putting that scare into him, he's putting it into himself'* [*sic*]. *On several occasions Mr. Desmond alludes to the possibility that he will "snap" if he has to deal with the nurse again and then "he'll really know what I'm like when I'm angry; he doesn't want to see me when I'm really angry." Writer asks what would happen if he became "really angry" and he states that he would be breaking things. He denies having any intention to be physically violent toward the nurse in question."* *"He states that if he has to deal with this nurse, he will either choose not to take his medication, or he will "pack his bags and leave"."*	
	Consistent with what Shanna Desmond described to Kama Hamilton on June 30, 2016, Mr. Desmond becomes fixated on benign encounters which result in exaggerated conflict, anger, and resentment. He does not seem to have the ability to let go and move on. The nurse conflict continues for the remainder of his time at Ste. Anne's. As late as August 12, 2016, three (3) days prior to his departure, Lionel Desmond again returns to the almost month-old conflict:	Exhibit P-000254 [page 263]

	"He expresses some irritation regarding this, but mainly emphasizes his beleif [*sic*] *that the nurse in question "knows what he did wrong". He states he doesn't care anymore what happens. He states that he doesn't like the way the nurse turns his head away or looks down at the floor when they pass eachother* [*sic*] *in the hall of the unit. Writer asked why he thinks the nurse avoids looking at him, and Mr. Desmond responds that the nurse is in denial about what happened, that he has his own fear and guilt, and emphasizes that he himself (Mr. Desmond) feels no guilt about the situation."*	
July 28, 2016	Lionel Desmond is still at the Ste. Anne's Hospital. It has been a month since he last spoke with Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette. He updates her on his progress and his plans to return to Nova Scotia on August 15, 2016. Lionel Desmond is leaving the program two (2) weeks early. He wishes to spend time with his daughter before she returns to school in September. He is eager to try to reconcile with Shanna Desmond and live permanently in Nova Scotia. Lionel Desmond and his case manager discuss moving forward with their working relationship despite how things left off near the end of June. Selections from Ms. Doucette's progress notes include: *a. "He said his house has sold, relieving him fomr* [*sic*] *significant stress. His plan will be to relocate to Nova Scotia upon his discharge from treatment. He anticipates this will be August 15."* *b. "It is expected a case conference, including CM and OSI team in Fredericton will take place in coming weeks."* *c. "Overall, veteran is getting some new insight from treatment. CM however found him to be talking around it, seems like an ongoing difficulty focusing on self and needs. Veteran complained about a particular staff who is no longer assigned to him as per his request."* *d. "Discussed VAC CM. Veteran was apologetic, said he had a lot on his mind (i.e.: whether he would remain in treatment) and acted innapropriately* [*sic*]*."*	Exhibit P-000117 [page 11]

	e. *"Veteran reinforced he is glad to be talking to CM today and is okay with continuing the working relationship until a transfer to NS is in effect."*	
July 29, 2016	Lionel Desmond discloses to Social Worker Kama Hamilton historical details of his marriage to Shanna Desmond including his own infidelity: *"It appears that he developped* [*sic*] *a relationship first with* ████ [Shanna Desmond] *and then years later (at age 19) began dating her. He left for military service shortly after they began dating, and states that they were "on and off" until he gave her an engagement ring when home on leave. Mr. Desmond admits that he cheated on his wife with two different women while on trips with the band. He states that he doesn't know why he did this, but that he envied his colleagues who were unattached and free to do what they wanted when on tour."*	Exhibit P-000254 [page 254]
July 29, 2016	Social Worker Kama Hamilton met with Lionel Desmond to discuss his plan for his eventual discharge from Ste. Anne's. Mr. Desmond's plan is scattered and uncertain. He wishes to live in Antigonish with his wife and daughter. However, this seems to ignore the reality that Shanna Desmond expressed, at least in the near future, that she does not want him in the same household. It also highlights a lack of full appreciation that the plan may not be in his best interests medically. Kama Hamilton's report from July 29, 2016, notes: *"He states that he intends to live with his Wife and her parents until he finds a new house. His discourse indicates that he is planning for his wife and daughter to move with him when they buy a new home. He states that* ████ *and his wife have accepted that he move in with them temporarily, but he admits that he does not want to stay for very long as he knows he will need his space, and feels they should be living autonomously as a family."*	Exhibit P-000254 [page 260]
	"Writer asked if Mr. Desmond would consider renting an apartment in Antigonish as an alternative to the above plan. Proposed that in this way both he and his wife would have the time and space they need to rebuild their relationship and it would allow him a place to go when he is feeling agitated or overwhelmed. He states that he would not do that because renting is "throwing your money away"."	Exhibit P-000254 [page 260]

August 3, 2016	Psychologist and Case Coordinator Dr. Isabelle Gagnon had a one (1) hour meeting with Lionel Desmond. Also present at this meeting is Occupational Therapist Julie Beauchesne, Social Worker Kama Hamilton, and Psychoeducator Marie-Ève Royer. The meeting is to address the altercation and ongoing conflict Lionel Desmond has with a specific member of the nursing staff. Dr. Gagnon noted: *"This meeting has the dual purpose of informing the client of the behavior expected of him and of practising new skills with regards to anger management. The client initially shows signs of anger and interrupts the clinicians in order to explain that the actions of the mental health nurse are solely responsible for his behavior. He shows signs of being agitated and states that he felt he had to walk away from the situation before becoming violent."*	Exhibit P-000254 [page 293]
August 3, 2016	Lionel Desmond phones Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette from Ste. Anne's. He is described as being "calm," "polite," and "in a good mood." He is requesting details about his return flight to Nova Scotia. He advises that when he returns to Nova Scotia he wants to be involved with the group Trauma for Healing and continues to be unsure of the value of continuing with the group Marijuana for Trauma. Ms. Doucette contacts Ste. Anne's Social Worker Kama Hamilton about the upcoming case conference which will take place prior to Lionel Desmond's discharge from the program.	Exhibit P-000117 [page 11]
August 5, 2016	Ten (10) days prior to his discharge and during an individual psychotherapy session with Dr. Isabelle Gagnon, Lionel Desmond remains unable to resolve the conflict he feels towards the Ste. Anne's nurse. He remains entrenched in his frustration, anger, and fixation on blame. Equally notable is that his expression of distrust now extends to those who are actively assisting in his rehabilitation. Dr. Gagnon notes: *"The client initially denies anger, but then expresses emphatic anger regarding a conflictual relationship with a mental health nurse. He states that he understood the subtext in the previous group meeting regarding this situation, knows that we expect him to apologise and to "kiss [this nurse's] ass" and that this will not happen. Mr. Desmond also expresses his belief that the team is on the nurse's side and that he now finds himself alone."*	Exhibit P-000254 [page 295]

			*"**Interventions:** A breach in therapeutic alliance is identified and attended to. We empathically confront the client regarding his now completely negative perception of the RTCOSI and of the therapeutic relationship in contrast with past experiences."* *"**Observations:** The client arrives with a new hairstyle, a mohawk cut which he refers to as his warrior hairstyle. Mr. Desmond shows up to the session visibly angry but denies any concerns when the clinician enquires about his mood (poor eye contact, frown, abrupt movements, tense posture)."*	
Aug.	**9,**	**2016**	A telephone conference is held between the Ste. Anne's team and Lionel Desmond's outside care team. Mr. Desmond's outside care team includes Psychologist Dr. Mathieu Murgatroyd and Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette. Both review the various treatment and supporting recommendations put forth by the Ste. Anne's treatment team. These recommendations are deemed necessary to Lionel Desmond's stabilization and rehabilitation as he returns to the community. Many recommendations are put forward including the need for a neuropsychological assessment. Such an assessment appears to be the cornerstone in structuring an effective treatment plan moving forward. There are indications that Lionel Desmond has made the decision to leave the Ste. Anne's program early and before completion. Again, leaving the residential program early and while actively showing signs of destabilization heightens the need for timely community intervention. New Brunswick OSI Psychologist Dr. Mathieu Murgatroyd made the following note: *"The writer was involved in a teleconference with the team members from Ste. Anne's who discussed Mr. Desmond's program. Mr. Desmond decided to leave his residential program early because he wanted to see his daughter before she started school. The team members briefly went over their recommendations, which included the need for a neuropsychological assessment to assist in determining his future treatment plan. They said they would fax their report to the writer in the coming days. Finally, the team expressed a few of their short term concerns, which included his*	Exhibit P-000244 [page 45]

			travelling plans back to New Brunswick and his living arrangements. The writer offered to meet with Mr. Desmond on Tuesday, August 16th, the day after he returns. The writer will contact Mr. Desmond to see if this time works with him, or whether he plans to return to Nova Scotia directly on August 15th. The writer and his CM to discuss plans to refer him to the OSIC in Halifax."	
			During this case conference Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette is made aware of several concerns expressed by the Ste. Anne's treatment team. Given his imminent return to the community these concerns call for timely intervention. 1) Mr. Desmond is leaving the program early. 2) "Minor progress" has been made in terms of treatment and stabilization. 3) Cognitive limitations are identified and require a comprehensive neuropsychological assessment. 4) It remains uncertain as to where Lionel Desmond is going to live once discharged in the coming days. 5) Mr. Desmond is in need of someone such as a clinical care manager to assist with managing his daily affairs and facilitating contacts/appointments. Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette made the following note: *"… CM participated in a Case Conference with Ste-Anne's Hospital treatment team. Fredericton OSI Psychologist, Dr. Mathieu Murgatroyd also participated as per CM's request. Many details regarding veteran's participation were shared. Veteran spent more than average time in stabilization unit and will be leaving the treatment program a bit earlier than expected as per his request to spend time with daughter before school starts. Overall, minor progress was observed and team expressed several concerns based on their observations of behaviour and what appears to be cognitive limitations. A neuropsychological assessment will be part of formal recommendations as further insight in his cognitive functioning is believed to be necessary. Some concerns are related to the veteran's lack of a sound plan for accommodations upon his discharge next week. CM and Ste-Anne team discussed some of the final*	Exhibit P-000117 [page 10]

			steps/discussions to be had with him prior to his departure. Since he will be relocating to Nova Scotia and will require new supports, the possibility of setting him up with services of a Clinical Care Manager was mentionned [*sic*]*."* *"Ste-Anne's report will be completed and forwarded to both CM and OSI clinic team via fax. Finally, Dr. Murgatroyd will offer veteran an appointment for August 16. CM prepared to authorized* [*sic*] *one hotel night if veteran decides to stay for this appointment as his house has sold during his absence and his new address is in Nova Scotia.* *Client Contact:* *No"*	
			It should be noted, despite the assurance that the Interdisciplinary Discharge Summary will be sent to Dr. Murgatroyd and Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette "in the coming days," it is not sent until October 7, 2016. There is an unexplained delay in sending this essential report. This delay is significant in that the report is not shared until almost two (2) months after discharge. There is no evidence that either Dr. Murgatroyd or Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette ever followed up as to why the report was taking so long. Naturally, such a delay would impact the effective implementation of timely and structured community intervention. After all, it was this report which contained the recommended interventions, how they were interconnected, and why they were essential. Despite the action items noted in the Interdisciplinary Discharge Summary, little if anything is in place when Lionel Desmond leaves the Ste. Anne's program. Nothing is arranged in terms of psychological counselling, marriage counselling, trauma intervention, social supports, medication monitoring/compliance, or neuropsychological testing. Mr. Desmond leaves the Ste. Anne's program with documented instability and heightened ongoing anger and distrust directed squarely at Shanna Desmond. He also leaves after having expressed distrust and resentment of Veterans Affairs Canada (VAC) along with the very medical professionals who have been trying to assist him. It is known that Lionel Desmond requires extended time to build a	Exhibit P-000244 [pages 45 and 84]

			therapeutic alliance with new professionals and time is clearly of the essence. Despite both Dr. Murgatroyd and Marie-Paule Doucette knowing that Lionel Desmond has a clear desire to move to Nova Scotia, no immediate contact is made with the OSI clinic in Nova Scotia. Dr. Murgatroyd agrees to continue to assist, however, recognizes the difficulty in doing so given Lionel Desmond's unstable living situation and desire not to stay in New Brunswick. Mr. Desmond has expressed his desire to leave New Brunswick given that it serves as a trigger for past trauma.	
Aug.	**9,**	**2016**	**Telephone Conference – Dr. Murgatroyd/New Brunswick OSI, Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette, and Ste. Anne's Clinical Team** It is noted that Lionel Desmond decided to leave the Ste. Anne's program early. He wanted to see his daughter before she started school. Recommendations are reviewed "briefly." The need for a neuropsychological assessment is highlighted. Dr. Murgatroyd makes the following note: *"They said they would fax their report to the writer in the coming days. Finally, the team expressed a few of their short term concerns, which included his travelling plans back to New Brunswick and his living arrangements."* **Continuity of Care Gap #8: Accessing Nova Scotia Resources including Nova Scotia OSI Clinic: Approximately 1 year and 4 months (April 16, 2015, Canadian Armed Forces (CAF) referral to community-based treatment/New Brunswick OSI to August 16, 2016, discharge from Ste. Anne's)** Dr. Murgatroyd again discusses with Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette the possibility of having Mr. Desmond referred to the Nova Scotia OSI Clinic in Halifax. It is notable that such a referral and need for Nova Scotia resources has been documented without action as far back as a year. At a minimum, it dates back approximately 11 months as referred to in Dr. Murgatroyd's entries on October 22, 2015, and October 23, 2015.	Exhibit P-000244 [pages 45, 75, 76 and 77]

August 9, 2016	The Ste. Anne's case conference is held. Present at this case conference is Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette, New Brunswick OSI Psychologist Dr. Mathieu Murgatroyd, and health care professionals from the Ste. Anne's Hospital. The purpose of this case conference is to coordinate Lionel Desmond's continuity of care once he returns to a community setting. Ms. Doucette is advised as to Lionel Desmond's lack of progress in achieving psychosocial stability. She is also notified of the immediate need for additional interventions such as a neuropsychological assessment and assigning a clinical care manager. A clinical care manager works as an extension of the Veterans Affairs Canada (VAC) case manager. This is a person, usually a social worker, who is contracted by Veterans Affairs Canada (VAC) for a specific period of time. Not every veteran will have a clinical care manager, however, one will be considered if there is a complexity to the veteran's needs. The clinical care manager assists with stabilizing the veteran's situation. They identify and coordinate various supports and services unique to a particular veteran's needs. They assist a veteran in organizing and structuring their day-to-day rehabilitation which includes setting up and maintaining appointments. They also monitor a veteran's progress. Ms. Doucette testified:	Exhibit P-000117 [page 10]
	"Like an example of times where we've used clinical care managers, certainly where there's a certain complexity to their needs, but also when a veteran relocates to a new area and it happens and . . . because life goes on even though you're in rehabilitation."	Transcript June 22, 2021 [pages 35 – 36]
	"The first time I remember the option of a clinical care manager being brought up and seriously considered was at the pre-discharge telephone meeting that we had with Ste. Anne's staff and I had asked Dr. Murgatroyd to be part of that call as well. And it was definitely like a unanimous, like everybody agreed that, at that time, given the changes in this veteran's situation, that the CCM would be an appropriate resource."	Transcript June 22, 2021 [page 108]
	"Coming out of the call, I think the priority was, Okay, we now have someone who is coming out of treatment and who needs new treatment providers around him. So the CCM resource, to me, was something that needed to be prioritized because they were going to	Transcript June 22, 2021 [page 145]

	be someone sort of on the ground, familiar with Nova Scotia systems, and could provide sort of that extra help." Highlights from Ms. Doucette's progress note relating to this case conference include: a. "*Veteran spent more than average time in stabilization unit and will be leaving the treatment program a bit earlier than expected as per his request to spend time with daughter before school starts."* b. *"Overall, minor progress was observed and team expressed several concerns based on their observations of behaviour and what appears to be cognitive limitations. A neuropsychological assessment will be part of formal recommendations as further insight in his cognitive functioning is believed to be necessary."* c. *"Some concerns are related to the veteran's lack of a sound plan for accommodations upon his discharge next week."* d. *"Since he will be relocating to Nova Scotia and will require new supports, the possibility of setting him up with services of a Clinical Care Manager was mentionned* [*sic*]*."* e. *"Ste-Anne's report will be completed and forwarded to both CM and OSI clinic team via fax. Finally, Dr. Murgatroyd will offer veteran an appointment for August 16."* Lionel Desmond ultimately declined the August 16, 2016, appointment with Psychologist Dr. Murgatroyd. Understandably, his preference is to fly directly home to Nova Scotia rather than fly to New Brunswick for an appointment on the first day following his discharge. However, his desire to remain in Nova Scotia will prove to be problematic to the original plan. Such a plan was to continue with the necessary support of the OSI specialists which were Psychologist Dr. Murgatroyd and Psychiatrist Dr. Njoku. Lionel Desmond's move to rural Nova Scotia will result in him losing these two (2) valuable and critical supports. Ms. Doucette testified to the following:	Exhibit P-000117 [page 10] Transcript June 23, 2021 [page 186]

	"So had Mr. Desmond, and I'm not faulting him for this, I'm just doing a comparison, had he released to New Brunswick where he already had providers in place, he would have been right back in with his psychologist and his psychiatrist. Perhaps the neuropsych would have been the first thing that we would have tried to initiate because those resources were in place to continue to work." During the critical period, which is leaving Ste. Anne's on August 15, 2016, and the closing of the New Brunswick file on December 22, 2016, little to no communication or coordination occurs between the entities of Veterans Affairs Canada (VAC) and the New Brunswick OSI Clinic. *"**Q.** So, basically, between August and December 22nd, outside maybe one phone call, is it fair to say that it's most likely that you and Dr. Murgatroyd did not communicate?* ***A.** Outside of that one phone call and then the letter that he sent, it's possible, yes."*	Transcript June 23, 2021 [page 146]
August 10, 2016	Five (5) days prior to his discharge Lionel Desmond continues to struggle significantly with various aspects of his mental health. Several things are notable and concerning. Despite having spent months in an intensive residential program there remain serious questions about the level of progress actually made. This lack of progress does not appear to be attributable to insufficient efforts made by the Ste. Anne's professionals, but rather serves to highlight the complexity and deepness of Mr. Desmond's condition. One would naturally ask what effect this lack of progress will have on his imminent return to the community, marriage, and personal relationships. This should be evaluated in the context of Mr. Desmond's noticeable ongoing instability, continued life stressors, emotional deregulation, anger, and mistrust. There is a heightened importance that the recommended interventions be implemented in a timely manner. Mr. Desmond not only demonstrates that he is still very much in a state of mental health turmoil, but also that he still requires considerable reinforcement to build confidence/trust with the healthcare professionals responsible for his intervention. During an individual psychotherapy session with Dr. Isabelle Gagnon he refers to himself as a "lone wolf." He advises Dr. Gagnon that he	Exhibit P-000254 [page 297]

	protects "himself by not trusting anyone." He continues to express deep distrust for his treatment team and is clearly not coping well. His affect is flat and he is focused on traumatic memories. He describes himself as feeling paranoid and that others are talking behind his back. He states that he would like someone to accompany him to the airport as the taxi driver is likely to speak a foreign language. He feels uncomfortable with not knowing where he might be taken. The following note is made: *"… he feels the treatment team is talking behind his back and that when he hears professionnals* [*sic*] *talking french* [*sic*] *he feels they are talking about him. He tells the clinician that she may think the walls are soundproof, but that word still gets around. He refuses to clarify the meaning of this statement. The client refers to his distrutful* [*sic*] *side as a lone wolf and identifies thoughts pertaining to protecting himself by not trusting anyone. He explains that this would be related to his military service and describes his experiences with the retrival* [*sic*] *of mangled bodies."* *"He explains that when he is in a taxi and the driver speaks a foreign laguage* [*sic*]*, and even more so when this individual is of middle eastern origin, he begins to feel uncomfortable not knowing where he is being taken and what is being said. He caracterises* [*sic*] *this tendency as being paranoid and draws a parallel with his worries about the team speaking french* [*sic*] *during his stay at the unit."* *"A breach in therapeutic alliance is identified and attended to. The distress felt by the client regarding matters of trust is emphatically reflected. We share our own sadness that the client believes he is alone in his struggle."* *"**Observations:** The client is alternately guarded and open. His affects are flat as he describes traumatic memories.* ***Points to follow-up:** Not applicable due to the client's imminent departure."*	
August 10, 2016	In anticipation of Lionel Desmond's upcoming release from Ste. Anne's, Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette contacts OSISS Peer Support Coordinator Glenn Park. Ms. Doucette is looking to arrange peer support for Lionel Desmond. However, Lionel Desmond also declines this service on the basis that	Exhibit P-000117 [page 10]

	his immediate focus is severing ties with New Brunswick and returning to Nova Scotia. There is now a necessity and urgency in setting up supports in Nova Scotia. Veterans Affairs Canada (VAC) had been alerted to the reality that Lionel Desmond had committed himself to returning to Nova Scotia as early as May 25, 2015. Over those 15 months there appears to have been little to no pre-emptive efforts by Veterans Affairs Canada (VAC) to identify suitable resources in rural Nova Scotia.	
August 12, 2016	Three (3) days prior to his discharge from Ste. Anne's, Lionel Desmond continues to struggle with overwhelming anxiety surrounding his pending return to the community. The following note is made by Social Worker Kama Hamilton: *"Mr. Desmond states that for his return home he plans to "take it slow, play it by ear, go with the flow," etc. He appears to have difficulty making a concrete plan, and seems unable to consider alternate plans in the case that his first plan does not work.* *Follow up: confirm date of departure with external team, plan teleconference, reschedule telephone conversation with Mr. Desmond's wife."*	Exhibit P-000254 [page 264]
	"Meeting to clarify Mr. Desmond's plans for the day of his departure. Mr. Desmond states that he was assured that he would be driven back to the airport for his flight home. The writer explained that clients are rarely accompanied unless there is an indication that the person is unable to go on their own. Asked Mr. Desmond if he is feeling anxious and feels he requires aid from an employee for this. *Mr. Desmond begins to show signs of agitation and quickly becomes activated. He expressed anger, stating that the arrangement was "set in stone" and that as a veteran he should not have to deal with paying for his taxi, nor is he willing to keep the receipt to be submitted for reimbursement."* *"Mr. Desmond remained agitated …"*	Exhibit P-000254 [page 265]
August 12, 2016	On this same date Social Worker Kama Hamilton met with Lionel Desmond to address a telephone call she received from his wife	Exhibit P-000254 [page 263]

	Shanna Desmond. Lionel Desmond is asked to provide his consent which will allow Ste. Anne's staff to contact her. Lionel Desmond is somewhat reluctant and uninterested in engaging in a conversation with his wife. The purpose of the contact is to discuss his imminent discharge. Kama Hamilton's report reads as follows: *"Meeting with Mr. Desmond for regular follow up & to address telephone call from his wife. Mrs. Desmond contacted the writer by telephone asking for information regarding Mr. Desmond's progress and readiness to return home. Writer informed.* [*sic*] *Mrs. Desmond that this is a conversation we would need to have in the presence of her husband."* *"Aked* [*sic*] *how he feels about having a telephone conversation with his wife in the presence of the writer and psychologist, Dr. Isabelle Gagnon. Mr. Desmond appears tired, down (head in hands, eyes closed,* [*sic*]*). He responds with ambivalence, saying he's just going to "go with the flow" and do whatever he's asked.* *At this point, Dr. Isabelle Gagnon joined the meeting, as writer had requested her presence during the telephone conversation. The psychologist and the writer asked Mr. Desmond to give a clear answer to whether or not he authorized us to contact his wife to discuss his discharge. He accepted, and the writer made the call. Mrs. Desmond did not answer the telephone …"*	
August 12, 2016	Social Worker Kama Hamilton is later able to arrange the telephone call between Lionel Desmond and Shanna Desmond. Occupational Therapist Julie Beauchesne was also present for this call. The phone call did not go well. The verbal exchange between Lionel and Shanna Desmond was filled with argument, interruption, anger, shouting, and swearing. Clearly, the status of their marriage was in doubt and both appeared to be at a loss as to how the damage could be repaired. Kama Hamilton's report reads as follows: *"Writer and OT reviewed the purpose of the telephone conversation with Mr. Desmond prior to making the call to his wife. Asked him what his expectations/hopes were for the conversation, as well as any limits he would like to put on the types of things discussed. Mr. Desmond seems slightly more animated than he had been the first time this was discussed (see previous note). He states however that he will listen to what his wife has to say and will respond if he feels able."*	Exhibit P-000254 [pages 266 – 267] Exhibit P-000254 [page 266]

	"Writer called Mrs. Desmond, informed her of the people present and asked that she begin by stating what her main concerns/questions are. *Mrs. Desmond asked generally how Mr. Desmond is doing, and wanted to know if he has made progress on the unit. She went on to say that she feels his paranoia and anger towards her have increased and described the dreams he has told her about in which he finds her in bed with another man and then "cuts her into a million pieces". Mr. Desmond appears discouraged by these comments saying he hasn't had a dream like that in a while. He then becomes increasingly angry about his wife bringing up "the past"."*	Exhibit P-000254 [page 266]
	"Through the course of the conversation, both Mr. Desmond and his wife expressed a great deal of frustration and anger. In Mr. Desmond's case this entailed shouting and swearing and repeating himself. On many occasions, the writer and Mme Beauchesne attempted to stop both from speaking at the same time."	Exhibit P-000254 [page 266]
	"Mrs. Desmond's main concerns were that she feels he remains too volatile and angry. She wants reassurance that he is able to regulate his moods (unfortunately, Mr. Desmond's behaviour during the phone call clearly demonstrated to her that he continues to struggle with this)."	Exhibit P-000254 [page 266]
	"Mr. Desmond expressed anger and hurt that his wife had left him alone in New Brunswick for the years they were separated. He eventually acknowledged that he understood why she left and agreed that is [sic] *was the right decision for their daughter and even apologized for interrupting her when she was trying to speak and for shouting."*	Exhibit P-000254 [page 266]
	"Writer and Mme Beauchesne emphasized the importance of the fact that they'd been able to hear eachother [sic] *out. Mrs. Desmond was able to acknowledge that she had not been with him when he needed her, and Mr. Desmond expressed understaning* [sic] *of her decision to leave. Writer pointed out that this is a new starting point for them and can help to rebuild their relationship, but*	Exhibit P-000254 [pages 266 – 267]

	suggested that they would benefit from a couples therapist to help coach them through this process."	
	"Asked Mrs. Desmond if she had any other questions, or concerns, but at this point she hung up the phone (suspect she had become too emotional to continue)."	Exhibit P-000254 [page 267]
	"Mr. Desmond seemed exhausted and saddened by the conversation. He is now questionning [*sic*] *whether or not he is welcome to live with his wife when he goes home. Discussed again the possibility of him having an apartment or condo rather than moving into his in-laws home and he appeared more open to this option, although became stressed by the thought of having to go through the process of buying a place."*	Exhibit P-000254 [page 267]
August 12, 2016	Helen Boone has a masters degree in social work. She has been employed as a social worker since 2002. Currently she is a manager of Mental Health and Addictions Opiate Recovery Program Eastern Zone, Nova Scotia. In addition to her employment with various agencies and organizations, she has operated a private practice since 2012. In her private practice she has experience in working with both veterans and members of the Canadian Armed Forces (CAF).	Exhibit P-000287
	In 2016 Ms. Boone was put on an approved list of private service providers for Veterans Affairs Canada (VAC) through Blue Cross. This was limited to providing counselling services. Until her involvement with Lionel Desmond in 2016, she had never been contracted by Veterans Affairs Canada (VAC) to act in the capacity of a veteran clinical care manager.	Exhibit P-000117 [pages 9 - 10]
	The first documented mention of Helen Boone being considered for the role of Lionel Desmond's clinical care manager occurs on August 12, 2016. Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette's progress note reads:	
	"CM to go through steps of approving resource and confirm with CCM - Social Worker Helen Boone in Sydney, NS who has tentatively agreed to playing this support role."	Exhibit P-000117 [page 10]
	Ms. Boone testified as to what she believed the role of a clinical care manager to entail.	

	"So, with being a clinical care manager, some of the things that I do is I help clients by identifying what are some of the needs of that client that are the wraparound supports that can help that person transition into success? How can I help that client navigate and identify resources of supports that will be helpful to them? I also directly work specifically with the case managers that would be involved. *When we identify what some of the needs and goals are, I may have to then go to the case manager to see can we get some support? Can we make sure that there's funding that's involved? And if there's no funding through, for example, Veterans Affairs, is there other areas in the community where we can secure funding? We look at the actual community that is involved and what supports are available in that community. I would be responsible for creating with the client mutually-identified goals to work on, look at how we're going to accomplish that. So how do we measure those outcomes? I try to identify action plans to have step-by-step examples of how we will reach the goals. And, again, it's something that there is ongoing assessment where, again, we're going to be looking at building blocks, one issue at a time and one need at a time, to ensure that there's success for the client."*	Transcript April 21, 2021 [pages 21 - 22]
	Ms. Boone also testified to the unique barriers and lack of mental health resources in rural settings: *"Unfortunately, our rural settings are more challenged with not having the types of resources that are afforded to the bigger metropolitan areas, so it is challenging, yes. And when, as workers, we are used to working in rural settings with very limited resources, we have to become very skilled at being creative when it comes to looking for these resources, and the one benefit that I think we have is that many of us have networked and that's part of what we do for our profession, so we get to know some of the folks that are doing various types of work and . . . but it is challenging, yes.* *…* *Sometimes, yes, because there's not . . . just by the numbers, there's not an . . . we don't have the numbers that they would in a bigger metropolitan area, so there's not a great big list to choose from. Not*	Transcript April 21, 2021 [pages 23 – 25]

	everybody has the skill-sets that are being sought after in rural settings. And just by distance alone, it takes more time to travel to areas and, yes, there can be barriers to successfully being able to connect with resources in rural settings."	
August 15, 2016	Lionel Desmond is formally discharged from Ste. Anne's Hospital. Given the nature of the phone call with Shanna Desmond three (3) days prior it remains unclear exactly where he is going to live. Curiously, the Interdisciplinary Discharge Summary report is devoid of any reference or recommendations to marriage/couples counselling or domestic violence intervention. Such references are missing despite the very recent and extended documented history of Lionel Desmond's anger, aggression, mistrust, and paranoia directed at Shanna Desmond.	Exhibit P-000254 [pages 268 – 274]
August 15, 2016	Lionel Desmond leaves Ste. Anne's Hospital, Quebec. Exactly where he is going to live in Nova Scotia is uncertain. He hopes to stay with Shanna Desmond and her family despite the recent rise in marital tensions and the problems he has had with her family in the past. Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette and the Ste. Anne's professionals express concern over the stability of his housing plan. Highlights from Ms. Doucette's progress note include: a. *"With respect to housing, veteran was still unsure exactly what he would be doing. He planned to visit his grand parents and his daughter in NS upon arrival. Despite CM and Ste-Anne's team encouraging him to think about renting an apartment for himself - a safe place for him to retreat to as needed - veteran has expressed it is overwhelming for him to have a back up plan (will likely stay with wife and her family despite this having been problematic for him in the past)."* b. *"CM explained the services of a CCM to veteran. He initially did not seem to comprehend, kept stating that what he needs is neurofeedback for hi* [sic] *brian* [sic] *functioning. CM persisted to describe how having a CCM to help him set up new resources, establish new supports, follow through with treatment recommendations, etc. in NS could alleviate / prevent some of his stress and worries.*	Exhibit P-000117 [pages 9 – 10]

	He agreed this could be beneficial for him and confirmed his willingness to work with a CCM once he returns to his home province."	
August 16, 2016	Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette consults with the Veterans Affairs Canada (VAC) Regional Mental Health Officer (RMHO). The purpose of this consult is to discuss retaining a clinical care manager who could assist with coordinating provincial resources to fulfill the Ste. Anne's recommendations. Social Worker Helen Boone is being considered for the role of clinical care manager. She is located in Sydney which is two (2) hours away from Lionel Desmond's community. There are no other clinical care manager options available in closer proximity to Lionel Desmond. Veterans Affairs Canada (VAC) is very much aware that Lionel Desmond remains vulnerable. He has left the Ste. Anne's program early without having achieved stability. Substantial barriers continue to exist in his recovery related to: marriage, finances, housing, employment, social supports, mental health resources, and identified neuropsychological/cognitive deficits. It is obvious that when Lionel Desmond leaves the Ste. Anne's Residential Program on August 15, 2016, few, if any, supports are put in place for him. He returns home with considerable instability despite the interventions of the skilled professionals at Ste. Anne's, Quebec. Highlights from the Veterans Affairs Canada (VAC) database entry include: a. *"Before leaving for treatment, client was expressing increased levels of stress related to his family and marriage, as well as financial stressors. These issues appear to have continued to present for client as he engaged in treatment at St. Anne's over the past number of months. It appears that he had some difficulty focusing on his self-care and mental health needs as there were ongoing stressors presenting."* b. *"Client has decided to leave St. Anne's earlier than recommended as he would like to spend time with his daughter before she returns to school. There continues to be ongoing difficulties in relation to his relationship with his wife. While engaging in the inpatient program, client's home sold and he has made no long term accommodation plans. He is relocating from NB to NS and has no providers secured in the NS area."*	Exhibit P-000273 [page 9]

	c. "Ste. Anne's are recommending a neuropsychological assessment based on some concerns related to his cognitive functioning ability." *d. "Client's awarded condition of PTSD is continuing to create barriers to his reestablishment in the community post medical release, he has had minimal progress to date and has limited coping skills. MHO supports CM decision to explore CCM services for client at this time."*	
August 16, 2016	The Veterans Affairs Canada (VAC) system entry from this date refers to the possible retention of Social Worker Helen Boone to act as clinical care manager. The entry reads: *"CM has located a CCM who is 2 hours away from client's current residence; no other CCM options were available in closer proximity to client. MHO supports CM decision to connect client with this particular CCM."* Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette leaves a voicemail for Social Worker Helen Boone. Veterans Affairs Canada (VAC) has given the approval to move ahead with retaining her services to act as Lionel Desmond's clinical care manager.	Exhibit P-000273 [page 9] Exhibit P-000117 [page 9]
August 16, 2016	Lionel Desmond has now left the Ste. Anne's program. Dr. Murgatroyd attempts to contact him by phone without success.	Exhibit P-000244 [page 44]
August 17, 2016	A seven (7) page Interdisciplinary Discharge Summary report is prepared. This detailed report outlines observations and recommendations from the various Ste. Anne's professionals who treated Lionel Desmond between May 30, 2016, and August 15, 2016. The report includes summaries from the following healthcare professionals: (a) Dr. Isabelle Gagnon, Psychologist and Clinical Coordinator (b) Julie Beauchesne, Occupational Therapist (c) Kama Hamilton, Social Worker (d) Maria Riccardi, Therapist (e) Marie-Ève Royer, Psychoeducator (f) Liz Ferland, Physical Rehabilitation Therapist (g) Dr. Geneviève Richer, General Practitioner	Exhibit P-000254 [pages 268 – 274]

	(h) Dr. Robert Ouellette, Psychiatrist	
	As stated in the report the recommendations are made to "ensure his continuity of care in his community." While enrolled at Ste. Anne's Mr. Desmond participated in an extensive number of individual and group programs. Programs were offered during both the stabilization and residential phase. **Stabilization Programs** 1) Tasks and themes 2) Social Networking Systems 3) Motivation 4) Pharmacology 5) Physical reactivation 6) Relaxation 7) Art-therapy 8) Goals 9) Woodworking **Residential Programs** 1) Tasks and themes 2) My GPS (mapping) 3) Mindfulness 4) ACT (Acceptance and Commitment therapy) 5) PEACE (Program for Experiencing Anger with Control and Effectiveness) 6) Exposure: physical activities in the gym 7) Managing my emotions 8) Sleep management 9) Seeking strength (addictions) 10) Art therapy 11) Yoga	
	The following is an outline summary of the extensive list of recommendations put forward by the Ste. Anne's team of professionals.	
	Recommendation - Medical - Dr. Geneviève Richer, General Practitioner 1) Continue compliance and monitoring with the following medications:	Exhibit P-000254 [pages 13 – 14]

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<tr><td>a) Prazosin 2 mg</td><td>Nightmares</td></tr>
<tr><td>b) Seroquel XR 50 mg and Seroquel 25 mg</td><td>Anxiety and depression</td></tr>
<tr><td>c) Sublinox 10 mg</td><td>Sleep</td></tr>
<tr><td>d) Tylenol</td><td></td></tr>
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<u>Recommendations - Psychology - Dr. Isabelle Gagnon, Psychologist</u>

1) “Firstly, due to observed and reflected difficulties in the area of behavior inhibition and memory as well as reported incidents in which head injuries might have been present, we recommend a detailed neuropsychological evaluation.”

2) “Continued work in developing skills in emotional regulation would also seem beneficial in helping the client manage life stressors. Particularly, emotional self-regulation combined with affirmative expression of anger could be helpful in promoting effective interpersonal interactions.”

3) “… developing mentalisation [sic] abilities might help Mr. Desmond hold a nuanced image of people around him even in moments of frustration.”

4) “… implication in an individual, scheduled physical activity could also promote self-care and limit isolation while engendering minimal interpersonal stress.”
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<td>Exhibit P-000254 [pages 269 – 270]</td>
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<u>Recommendations - Occupational Therapy - Julie Beauchesne, Occupational Therapist</u>

1) “A neuropsychological evaluation is recommended in order to determine M. Desmond’s cognitive capacities.”

2) “A functional assessment by an occupational therapist is also strongly recommended in order to determine the client’s actual functional capacities or limitations. Having a clear portrait of the actual impact of cognitive deficits on the client’s functionning [sic], if any, will serve to orient treatment in that it will support the process of
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	setting realistic therapy goals which are to help Mr. Desmond attain a satisfying level of participation in his activities and develop a sense of having an improved quality of life." *"An assessment of the functional capacities will make it possible to identify the most appropriate level of support and strategies to be given to M. Desmond in order to help maximize his participation in carrying out obligations related to his different occupational roles (father, spouse, worker, friend,etc* [*sic*]*)."* **<u>Recommendations - Social - Kama Hamilton, Social Worker</u>** *1) "Wounded Warriors program: given Mr. Desmond's difficulties and high levels of stress in interpersonal relationships, any sort of pet therapy program has the potential to be beneficial to help him build trust, increase his sense of security in relationships and enjoy the calming effects of working with therapy animals. He also mentionned* [*sic*] *that if he is able to participate in the program he would like to involve his daughter and this might help to build his relationship with her (through sharing an* [*sic*] *mutually enjoyable activity rather than the more challenging aspects of interpersonal communication)."* 2) *"Neuro-feedback: Mr. Desmond expressed to the writer towards the end of his treatment on the unit that he feels his brain is "broken". He describes difficulty with memory, rapidly fluctuating moods, and difficulty concentrating (much of which was frequently observed on the unit). He states that his physician recommended that he receive neuro-feedback treatment and he hopes this treatment will help him to re-gain control over his moods and his reactions to stressful events or interactions."* *3) "Mr. Desmond would benefit from having a clinical care manager to help with the coordination of services, particularly given the fact that he will be transferring to a new team."* *4) "When Mr. Desmond became agitated on the unit, he often succeeded in taking control of his emotions through physical exercise. The writer therefore believes that*	Exhibit P-000254 [pages 270 – 272]

	participation in a leisure activity such as a cycling club would be beneficial. This type of activity would provide Mr. Desmond with an additional physical outlet beyond his regular routine while at the same time providing a social setting in which he can potentially benefit from the advantages of being a member of a group, without having the pressure to socialise when he feels unable to do so." 5) *"Continued participation in a yoga class: Mr. Desmond appeared to enjoy the yoga classes on the unit ..."*	
	Recommendations - Art Therapy - Maria Riccardi, Art Therapist 1) *"His goals were to gain new coping strategies to decrease intrusive thoughts and to engage fully in daily activities. Treatment includes the learning of relaxation techniques, cognitive restructuring and art-therapy interventions."* *"Mr. Desmond was seeking help to learn strategies to cope with worry and anxiety and to acquire a better sense of self."* *"For the participant, daily art making implies the use of different media to encourage the expression of emotions. However he would need guidance to learn to pace himself. Following treatment at the centre, art involvement in the community is encouraged. A psychotherapeutic art-based treatment is also strongly recommended."*	Exhibit P-000254 [page 272]
	Recommendation – Psychoeducator - Marie-Ève Royer, Psychoeducator 1) *"The main recommendation is that Mr. Desmond should be seen by an addiction counsellor because of his history of substance abuse and because he remains undecided as to his intentions to consume in the future."*	Exhibit P-000254 [pages 272 – 273]
	Recommendation - Osteopathy - Liz Ferland, Physical Rehabilitation Therapist	Exhibit P-000254 [page 273]

	1) *"Mr. Desmond is encouraged to continue to adopt an active lifestyle by participating in nordic walking and/or traing* [sic] *in the gym and/or a sport under the supervision of a qualified trainer (kinesiologist, physiotherapist or physical readaptation therapist) …"*	
	General Recommendations: *"**Managing emotions:*** • *Use the record of automatic dysfunctional thoughts to better identify these thoughts influencing your emotions;* • *Continue to practice Mindfulness;* • *Review the questionnaire regarding patterns;* • *Apply the principles of the Acceptance and Commitment Therapy (ACT) - letting to, committing to value-based concrete action, practise noticing;* • *Use the Weekly Record of Anxiety and Depression;* • *Practise cognitive re-evaluation and flexible thinking to reduce anxiety;* ***Pain management:*** • *Continue to improve and maintain optimal physical fitness through a healthy lifestyle.* ***Interpersonal relationships:*** • *Seize opportunities to expand your social network by becoming involved in your community and taking part in social activities with those close to you.* • *Participate in group meetings organized by OSISS;* • *Continue to apply effective communication strategies to help you communicate better with those around you.* ***Daily functioning and organization:*** • *Schedule your time weekly and use a day planner to keep to an organized, balances* [sic] *and satisfying routine and encourage a feeling of accomplishment.* ***Sleep problems:*** • *Review the information provided on insomnia;* • *Keep a sleep diary;* • *See your doctor before making any changes in the medications prescribes* [sic] *for your sleep problems."*	Exhibit P-000254 [page 273]

	It becomes apparent that the recommendations for continuity of community care are exceptionally detailed and comprehensive. The recommendations are also technical and complex in nature. They will require several healthcare professionals operating and sharing information together. Fundamentally, Lionel Desmond is identified as a person overwhelmed by daily life stressors. He lacks a permanent residence and is without a strong social support network. He is identified as suffering from cognitive limitations paired with difficulties with memory and concentration. He has proven to be non-compliant with medication. He is easily angered, frustrated, overwhelmed, and paranoid. His marriage has broken down and it is taking a toll on his mental health. He continues to spiral downward even while showing improvement in some areas. In fairness to Mr. Desmond, it would be impossible for him to even begin to navigate or understand the details of these recommendations on his own. Yet, they are never reviewed with him after he walks out the door. Taken a step further, little was done to put the resources in place to allow that process to begin. Simply put, recommendations were made but were never communicated, reviewed, or implemented. He was a man in a state of mental health crisis when he left Ste. Anne's on August 15th, 2016. He left with a backpack full of recommendations and questionable insight into their importance, what they meant, who was going to implement them, and how he was going to access these services. The cold reality is that these were not going to be implemented in a timely fashion, if at all.	
August 22, 2016	Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette is based out of New Brunswick. Lionel Desmond has now returned to Nova Scotia and a decision is made that Ms. Doucette will temporarily "… stay connected to the veteran until some services are secured and a certain stability is achieved." Ms. Doucette testified to the added complication created by the fact that Lionel Desmond is also returning to a rural community within Nova Scotia. As a result, resources and services will be more limited. It is notable that Ms. Doucette is unfamiliar with what resources may be available near his home community. Ms. Doucette testified:	Exhibit P-000117 [page 9]

	a. *"But, obviously, I'm not as familiar with everything that is offered in northern Nova Scotia. That's not my province of residence and so that's when, you know, having a kind VSTM from the Halifax office say, Well, how about I connect you to a few people who you can ask questions to if you hit roadblocks or whatnot in terms of resources."*	Transcript June 22, 2021 [page 155]
	b. *"And, because of the rural area that he was moving to, it was hard to find. Well, we couldn't find someone qualified and registered very close to where he lived, but there was one person who I think you heard from in the Inquiry, Helen Boone, who was out of Cape Breton and willing to take on that role."*	Transcript June 22, 2021 [page 146]
	c. *"And, specifically in the case of Mr. Desmond, the CCM was the one that I felt, because of the geographical change too, would be a great asset in terms of knowing a bit more what was around, understanding, you know, if there were any differences with the provincial system, because there was also the decision to maintain him on my caseload until we had some stability of supports around him."*	Transcript June 22, 2021 [pages 149 – 150]
	d. *"**Q.** Was there anything preventing you from trying to look into what community resources were available in Nova Scotia when you had a pretty good idea that he's gong [sic] to end up coming out of there when he's done at Ste. Anne's.* ***A.** In all fairness, time. Like I said, there's a number of priorities that we're juggling. And the other piece, and I'm not trying to discredit what you're saying, I understand that. Ideally, we're looking ahead, we're being proactive. But if I had done what I was really supposed to do, I would have reassigned him to someone in Nova Scotia when he left treatment so I would not have been looking for resources for him at all."* Veterans Affairs Canada (VAC) has given the approval to move ahead with retaining Social Worker Helen Boone's services to act as Lionel Desmond's clinical care manager. Ms. Doucette also leaves a voicemail for Lionel Desmond advising the same.	Transcript June 23, 2021 [page 156]
August 24, 2016	**<u>Phone Contact New Brunswick OSI</u>**	Exhibit P-000244

	Dr. Murgatroyd has his first contact with Lionel Desmond since he left the Ste. Anne's program a week prior on August 15, 2016. Lionel Desmond reports the following: 1. He is doing "generally well." 2. His new medication is helping, and he wishes to abstain from marijuana. 3. He is living in Antigonish at his in-law's residence. 4. He has been assigned a CCM in Nova Scotia. 5. He would like further neuropsychological testing as recommended by Ste. Anne's staff. 6. He would like to engage in neurofeedback therapy. Dr. Murgatroyd notes the following: *"Once again, it seems like the priority for Mr. Desmond is trying to work things out with his family. He is interested in having his file transferred to Nova Scotia. The writer will contact his current CM, Ms. Doucette, to discuss his transfer as well as looking into community resources. In the meantime, Mr. Desmond was encouraged to contact the writer if he needs to."*	[page 43]
August 24, 2016	Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette speaks with Lionel Desmond about retaining Helen Boone to act as his clinical care manager. Lionel Desmond is in full support of this and eager to have her assist in his rehabilitation. Ms. Doucette's progress note from this date reads: *"CM reminded him of her plan to connect him to CCM (Social Worker) Helen Boone. He remembered the conversation and indicated he is ready for her to connect with him at any time. Verbal permission given to CCM to initiate services by contacting CCM."* Unfortunately, despite both the willingness of Ms. Boone and Mr. Desmond to begin the rehabilitation work "bureaucratic barriers" will prevent this from happening.	Exhibit P-000117 [page 9] Transcript June 22, 2021 [page 229] Exhibit P-000299

		[page 7]
August 24, 2016	Lionel Desmond speaks with Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette. He confirms he is now living with his wife and daughter at her parents' residence in rural Monastery, Nova Scotia. When told that Social Worker Helen Boone will be assigned as his clinical care manager, he expresses that "he is ready for her to connect with him at any time." Lionel Desmond also advises that he attended a local pharmacy and was informed that his sleep medication (Sublinox/Zolpidem) which was prescribed by physicians at Ste. Anne's is not covered. Ms. Doucette confirms that she will assist with obtaining a special authorization to cover the medication cost. It is notable that a month later, on September 22, 2016, the medication cost approval is still not arranged and Lionel Desmond phones Veterans Affairs Canada (VAC). It is unclear whether or not Lionel Desmond ever proceeded with getting the prescription filled at his own expense. Concerning is the fact that he has a past history of declining to get prescriptions filled when the expense is not automatically covered. This, coupled with his long history of noncompliance with medication, makes it more likely than not that his condition will go unmedicated shortly after he leaves Ste. Anne's.	Exhibit P-000117 [page 9] Exhibit P-000273 [page 8]
Fall 2016	Chantel Desmond notices that Lionel Desmond's mental health appears to be deteriorating during the fall after leaving Ste. Anne's Hospital. She described him wearing his camouflage more often. She observed that his appearance was unkempt. She said: *"And he had no . . . there's nothing . . . no therapeutic things happening for him besides he had the marijuana, he had himself."* Chantel Desmond believed that there was conflict between Lionel and Shanna Desmond as she noticed that he would stay with Sandra and Kenneth Greencorn for a week or two (2) weeks at a time. This happened more during November and December of 2016.	Transcript February 17, 2021 [page 87] Transcript February 17, 2021 [pages 112 - 113]
September 9, 2016		Exhibit P-000117 [page 8]

	Before she can begin work, Ms. Boone is required by Veterans Affairs Canada (VAC) to register and complete BHSOL (Access Benefits and Health Services On-Line) training. Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette's progress note from this date reads: *"Ongoing communication between CM and Clinical Social Worker H. Boone who is prepared to assist this veteran via CCM services. She is in the process of registering / training with VAC's BHSOL; a pre-requisite for assisting veteran. CM will remain available to support her through this process with hopes of having her connected to veteran as soon as possible. Communication ongoing."* The Veterans Affairs Canada (VAC) BHSOL system is a computer onboarding system. It is used for the documentation/filing of client records. It is a computer program which allows the worker to make notes and document connections they have had with a veteran client. In the end, Ms. Boone testified that the BHSOL system was not complex and the training, once it became available, was fairly straightforward. It took "Maybe a couple of hours." Ms. Boone testified to her recollection of what she believed Lionel Desmond's circumstances were during her initial conversations with Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette. *"… I got the sense that if a clinical care manager was required for this, that it was very complex, that it's not just somebody seeking, you know, eight sessions for anxiety management techniques, for example. That there's a variety of needs, there's a variety of concerns, and given the fact that the person was inpatient and that it was recommended that the person had inpatient treatment, certainly, it means that things are more complex, but since the client chose not to continue with inpatient treatment, that it's important to try to ensure that as many supports and services were in place to help transition the client as successfully as possible."*	Transcript April 21, 2021 [pages 34 – 37 and 40] Transcript April 21, 2021 [page 32]
September 22, 2016	Despite best intentions to have Social Worker Helen Boone begin work as Lionel Desmond's clinical care manager a month has passed without any progress. Veterans Affairs Canada (VAC) Case Manager	Exhibit P-000117 [page 8]

	Marie-Paule Doucette speaks with Lionel Desmond for the first time in a month. She updates him with respect to three (3) things: delay in prescription coverage, delay in assignment of a clinical care manager, and delay in obtaining the Ste. Anne's report which contains treatment recommendations. Highlights from her progress note are as follows: a. *"CM has contacted Medavie a second time to follow up on the approval of meds that were prescribed to him by Dr. Ouellette at Ste-Anne's Hospital. CM advised veteran that the physician's paperwork was received at MAC and is pending authorization at this time."* b. *"CM also explained the administrative delays with respect to connecting with CCM. He was understanding and expressed his appreciation for CM's call. Overall, veteran states he is doing okay. Sorting out the medication details has been challenging and he is still considering whether he wants to purchase a house or not. No immediate issues noted. CM reminded him to be in touch if there are any changes to report in his health."* c. *"Otherwise, plans are to be in touch as soon as CCM is ready to connect and help him follow up on treatment recommendations. Ste-Anne's clinical Social Worker advised the report is near complete and will arrive to CM shortly."* An additional progress note from Ms. Doucette on this date reveals that she advised VSTM (Veterans Services Team Manager) that she "… is remaining connected to this veteran for time being, but will eventually request a file transfer." With Lionel Desmond now in Nova Scotia full time, Ms. Doucette feels it is appropriate that he have a case manager familiar with Nova Scotia and closer to that province.	Exhibit P-000117 [page 8]
September 30, 2016	Given that Lionel Desmond is now residing in Nova Scotia, the New Brunswick OSI team makes a referral of Lionel Desmond's care to the Nova Scotia OSI Clinic. New Brunswick OSI Psychologist Dr. Murgatroyd completes the "Inter-Clinic Referral Form" and sends it to Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette. Now that Lionel Desmond has permanently moved to Nova Scotia the intention is to have him connected with the resources of the Nova Scotia OSI	Exhibit P-000244 [pages 94 – 95]

		Clinic. The referral includes the New Brunswick OSI psychiatric notes of Dr. Njoku and the original December 15, 2015, Ste. Anne's referral. Dr. Murgatroyd's referral to Veterans Affairs Canada (VAC) reads: *"Client recently sold house in Oromocto, and is now settled in Antigonish with his wife and daughter. Client recently completed residential program at Ste Anne's. We are still awaiting the team's report (his CM will fax it to you). Requires psychiatric follow-up at the OSI in Halifax, and ideally a therapist in his community."*	
Sept. 30,	**2016**	**Inter-Clinic Referral New Brunswick OSI and Nova Scotia OSI** At this point there appears to have been no contact between Lionel Desmond and the New Brunswick OSI Clinic for approximately one (1) month (August 31, 2016). Dr. Murgatroyd completes the "Inter-Clinic Referral Form" and sends it to Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette. This referral includes the New Brunswick OSI psychiatric notes of Dr. Njoku, the original December 15, 2015, Ste. Anne's referral, and the note from Dr. Murgatroyd.	Exhibit P-000244 [pages 94 - 95]
September 30, 2016		The Nova Scotia OSI Clinic receives an inter-OSI referral from the New Brunswick OSI Clinic (Dr. Murgatroyd) by fax. It is received by Natasha Tofflemire, RN. The Nova Scotia OSI Clinic was still in its early stages of development at this time. At the time of receipt of this referral there were two (2) registered nurses employed at the clinic, of whom Ms. Tofflemire was one, who were in charge of intake and case management. Referrals typically came from Veterans Affairs Canada (VAC). The intake team would follow up with the Veterans Affairs Canada (VAC) case manager and then with the veteran to discuss with them what they were looking for and to do a suicide risk assessment. The referral would then be brought to the team of clinicians. On occasion a referral could come from another OSI clinic although there still had to be confirmation from Veterans Affairs Canada (VAC). The fax cover sheet for the referral from Dr. Murgatroyd states: *"Please find Inter - Clinic Referral Form for veteran Lionel D. Also attached are psychiatric notes on file by Dr. Njoku as well as letter recommendation to Ste. Anne's residential program. Client recently*	Transcript March 9, 2021 [pages 92 – 95] Exhibit P-000147 [page 3]

	completed the residential program. VAC is still awaiting SteAnne's [*sic*] *report."*	
October 6, 2016	The referral for Lionel Desmond is triaged by Nurse Tofflemire. At that time she speaks to Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette and makes the following entry: *"2016/10/06* *0900* *Called VAC Case Manager Marie Paule Doucette . . . to discuss referral of client by NB OSI. Case Manager voiced that client decided to proceed with a community therapist as he lives in Antigonish but that she will do a referral to the clinic for psychiatry as client is recently done in patient at Ste-Anne and requires psychiatry follow-up. She will verify if he has a family doctor before proceeding with the referral. File will be placed on hold until then."* At the time there was a delay in patients of the Nova Scotia OSI Clinic being able to see a psychiatrist. The file was then placed "on hold" until Veterans Affairs Canada (VAC) confirmed referral again.	Exhibit P-000147 [page 2] Transcript March 9, 2021 [page 111] Transcript March 9, 2021 [pages 116 - 117]
October 6, 2016	Nova Scotia OSI Intake Nurse Natasha Tofflemire contacts Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette by phone. The Nova Scotia Operational Stress Injury Clinic has received the September 30, 2016, inter-clinic referral from the New Brunswick Operational Stress Injury Clinic. This referral was completed by New Brunswick OSI Psychologist Dr. Murgatroyd. Nurse Tofflemire's note from this date reads: *"0900* *Called VAC Case Manager Marie Paule Doucette (506)721-5149 to discuss referral of client by NB OSI. Case Manager voiced that client decided to proceed with a community therapist as he lives in Antigonish but that she will do a referral to the clinic for psychiatry as client is recently done in patient at Ste-Anne and requires psychiatry follow-up. She will verify if he has a family doctor before proceeding with the referral. File will be placed on hold until then."* Ms. Doucette did not make any contemporaneous notes or reports with respect to this important phone call with Nova Scotia OSI	Exhibit P-000147 [page 2] Exhibit P-000117 [pages 2 – 3]

	Intake Nurse Natasha Tofflemire. However, on January 11, 2017, after learning of the deaths of Lionel Desmond, Shanna Desmond, Aaliyah Desmond and Brenda Desmond, the following system entry is made: "*In early October 2016, this CM (as per the recommendation of the NB OSI team) explored the possibility of psychological and /or psychiatric services at the OSI clinic based in Halifax NS. After communication with a Nurse Case Manager, the option was presented to the veteran who declined based on the geographical distance from his rural town. Telehealth services were also discussed as part of this treatment proposal. Veteran declined these as well. To avoid further delays in accessing treatment, CM deemed a provider from the private sector was the best course of action at the time."* At the Inquiry Ms. Doucette testified:	
	"So I talked to him about that and he was still not interested. And so the last piece I explored with him was, Well, what about psychiatry services because he, you know, had some things prescribed to him at Ste. Anne's and was probably going to need the oversight of a psychiatrist for medication management. That stuff. I suggested that maybe it would be easier if he connected with a psychiatrist at OSI, and then if he wanted to work with a different provider for actual therapy, then that was a possibility too. *So we had that conversation. He decided that he wanted to work with professionals in his community. This is something that I clearly remember discussing with him. In reviewing my notes post-tragedy, I realized that it wasn't documented, (a) because I was on the road and (b) because he decided not to go ahead with it. I don't know if, at the time, I thought, well, move on to the next thing, but it was documented after the fact in a different report."* Ms. Doucette is aware that a treating psychiatrist is essential to Lionel Desmond's rehabilitation. Curiously, once he elects to pursue this resource in his community rather than at the Nova Scotia OSI Clinic in Halifax the discussion seems to end. Ms. Doucette never attempts to assist in coordinating this resource near his rural community. She never follows up with him to determine whether or not he has had any success in finding a psychiatrist.	Transcript June 22, 2021 [pages 166 – 167]
	*"**Q.** … did you ever once ask him, Did you ever find a psychiatrist?*	Transcript June 23, 2021

	A. *I don't remember. I have instructed him to always let me know when there's a change so that we can be on top of that, but if I asked that question specifically, I don't recall.* ***Q.*** *And it's fair to say, if you asked that question in the fall of 2016, you would've learned about the existence of Dr. Slayter?* ***A.*** *Potentially, yes.* ***Q.*** *And if you knew about the existence of Dr. Slayter, I guess it's fair to say you would've became engaged to the extent of maybe suggesting to Lionel Desmond somehow that Dr. Slayter could start to liaise with Helen Boone, Catherine Chambers. Is that something you would've done?* ***A.*** *Yeah, well which was the point of having a CCM involved was that if there is a need for the psychologist and the psychiatrist to be connecting, then we can facilitate that."*	[page 124]
	"***MR. RUSSELL:*** *Is it possible that you, at times, might've overestimated Lionel Desmond's ability to make those contacts and resources, such as when it came to psychiatry?* ***A.*** *It's possible."*	Transcript June 23, 2021 [page 132]
	*"**Q.** … is it possible that you might have overestimated his ability to find a psychiatrist in his community in Nova Scotia and to be diligent in following up with that psychiatrist?* ***A.*** *It's possible, yes. He gave me the impression at that . . . during that conversation that he was capable and that he was going to go look for that. And if I didn't do follow up in due time, I take responsibility …"* Furthermore, Ms. Doucette was given an opportunity to review Nova Scotia OSI Nurse Natasha Tofflemire's note from October 6, 2016. She was asked to comment on two (2) things: 1) Ms. Tofflemire's documented suggestion that Ms. Doucette was going to verify whether Lionel Desmond had a family doctor before proceeding with the Nova Scotia OSI referral for psychiatry; 2) Whether Ms. Doucette was told or given the impression from the Nova Scotia OSI Clinic that having a family doctor was a prerequisite	Transcript June 23, 2021 [pages 165 – 166]

	or preferred requirement before accessing Nova Scotia OSI's psychiatry service. Ms. Doucette testified: a. *"**A.** I don't remember that specific detail. I think as I mentioned before, potentially because if that was necessary for a referral, I didn't consider it a huge hurdle that they would try to figure out if there was a physician in the local community. What I'm . . . I'm not questioning the note. I'm questioning the time that the note went in because, obviously, the conversation that I had with Mr. Desmond about psychiatry, which I had hoped that he would go to OSI for psychiatry, he turned down that option."*	Transcript June 23, 2021 [page 208]
	b. *"**Q.** And do you remember having any sort of discussion with her about him needing or preferred that he have a family physician before he is able to access that service in Nova Scotia, OSI?* ***A.** I don't recall. I don't recall that specific detail. However, it is quite possible that we discussed that ..."*	Transcript June 23, 2021 [pages 208 – 209]
	c. *"**Q.** Do you recall any sort of discussion about him and a family doctor? Do you recall ever bringing that up to him?* ***A.** Not specifically, no."*	Transcript June 23, 2021 [page 209]
	d. *"**A.** So was I telling her at that time, Okay, he already told me that he would prefer a therapist in the community but we will seek to get the services of a psychiatrist. Then I follow up with Mr. Desmond. He tells me, No, I don't want to go there for psychiatry. And then I am pretty confident that I called back but, like I said yesterday, I may have left a voicemail message letting her know that we weren't proceeding with a referral at that time."*	Transcript June 23, 2021 [page 210]
	Finally, during her Inquiry evidence Ms. Doucette was given an opportunity to review the October 18, 2016, entry from New Brunswick OSI Psychologist Dr. Murgatroyd. Lionel Desmond advised Dr. Murgatroyd on October 18, 2016, that "he is in the process of being assigned a family doctor." Ms. Doucette testified:	Exhibit P-000244 [page 42]

			*"**Q.** To your knowledge, do you know of anyone that said to Lionel Desmond that he was going to be assigned or have arranged for him a family doctor?* ***A.** No, I would only know that from him, if he provided me that information."*	Transcript June 23, 2021 [page 211]
Oct. 7,	**2016**		**<u>Ste. Anne's report provided to New Brunswick OSI</u>** **<u>Continuity of Care Gap #9: Lack of Sharing Medical Documentation in Order to Implement Effective Treatment Plan: Approximately 2 months</u>** There is a considerable delay in forwarding the vital August 17, 2016, Ste. Anne's Interdisciplinary Discharge Summary report. This report contains all recommendations for Lionel Desmond's continuity of care. It appears to have been in the exclusive possession of the Ste. Anne's Clinic for two (2) months while Lionel Desmond shuffled throughout the community having minimal access to mental health resources.	Exhibit P-000244 [pages 84 - 91]
Oct.	**7,**	**2016**	Approximately two (2) months after Lionel Desmond's August 15, 2016, discharge from Ste. Anne's a fax is sent to Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette and to Dr. Murgatroyd at the New Brunswick OSI Clinic. This fax is sent from Ste. Anne's Record Administrator Alexandra Nault-Duporge. The fax contains the seven (7) page August 17, 2016, Interdisciplinary Discharge Summary which was originally to be provided in the days following the August 9th, 2016, case conference. It is notable that no other records pertaining to Lionel Desmond's time at Ste. Anne's ever appear to be shared with or requested by outside community supports. This includes New Brunswick OSI and Veterans Affairs Canada (VAC). These "missing" reports/records are extensive and detailed. Upon review, they would appear to be of great value to any treating mental health professional. It is within these records that a mental health professional would find details of Lionel Desmond's day-to-day struggle, emotional deregulation, rapid change in mood, conflicts with others, distrust for healthcare professionals, past thoughts of suicide and attempt, and his inability to effectively implement various learned coping strategies.	Exhibit P-000244 [pages 84 – 91]

	As well, these records contain Shanna Desmond's valid repeated concerns for Lionel Desmond's mental health and her own well-being. This includes her desire not to leave Lionel Desmond alone with their daughter, how she is frightened when he yells, her concerns about his unpredictable angry episodes, the obsessive vile texting, and impulsive behaviour. These records also expressly outline Lionel Desmond's ever-increasing resentment, anger, and frustration towards Shanna Desmond as he moves towards returning to the community.	
October 12, 2016	Tensions continue to rise between Lionel Desmond and Shanna Desmond. As well, Lionel Desmond expresses his frustration with the lack of rehabilitation resources in rural Nova Scotia. He is also growing frustrated with the lack of coordinated supports and the sharing of information since he was discharged from Ste. Anne's two (2) months prior. He requests that Veterans Affairs Canada (VAC) provide him with a copy of the Ste. Anne's report and that he be assigned a new case manager. The client screening entry reads: "*Spouse doesnt* [*sic*] *understand PTSD, services not available where they are lving* [*sic*]. *Veteran very agitated, cursing and blaming his spouse for where they are living . Says he cant* [*sic*] *be in NS anymore (they live with spouse parents) . Thinks he may have to divorce spouse as she doesnt* [*sic*] *want to leave her current job. He would like to be assigned a CM in NS and also would like to have a copy of his discharge report from St ANnes* [*sic*] *so that he will know what he should be doing now for his PTSD . He gave up MM and is back to pills. He feels isolated and not supported. He hates where he is living as he complained there were not* [*sic*] *supports and there were many social problems such as addiction . He would like to have CM support to help him deal with all his issues."* At the Inquiry Ms. Doucette was asked if she ever provided Lionel Desmond with a copy of the Ste. Anne's Interdisciplinary Discharge Summary: *"**Q.** So did you ever provide Cpl. Desmond with a copy of the discharge summary that he asked for?* ***A.** I don't remember if …* ***Q.** Okay.*	Exhibit P-000292 [page 2] Transcript June 23, 2021 [pages 107 – 108]

	A. *If I specifically gave him a copy. I would have had to put that in the mail and it's possible, but I don't have recollection."*	
October 13, 2016	Lionel Desmond attended the Guysborough Medical Clinic and met with Dr. Luke Harnish. Dr. Harnish is an emergency medicine doctor who was doing a locum at the Guysborough Medical Clinic.	
	Mr. Desmond was wondering about his follow-up plan coming out of Ste. Anne's Hospital in Quebec. He was accompanied by his wife. According to Dr. Harnish, Lionel Desmond "didn't, I think, know what the plan was and didn't know where else to turn, I think, at that point so he came in to see if we could help him."	Transcript March 10, 2021 [page 137]
	The chart entry states the following: *"Recently moved back to Guysborough after being away for approx. 11 years. here with wife today was in military and served overseas He reports that he was discharged at some point due to depression, stress and PTSD was recently admitted to a military hospital in Montreal (Ste. Anne's Hospital) for three months due to nightmares and sx of PTSD received targeted counselling and therapy as well as medications and symptoms were under control. He was discharged and subsequently moved back to NS.* ***He believes they were suppose*** [*sic*] ***to set up FU in NS however so far has received none. He has been home for 2 months and does not have a copy of his chart to verify treatment, diagnosis and plan****."* [Emphasis added] The chart also contains the following: *"Lately he is finding that he is having more vivid dreams that he remembers He says the goal of his treatment was no* [*sic*] *to decrease frequency of dreams but rather decrease his ability to remember* *He also reports at times being more agitated and has contemplated drinking, but does not want to start this.* *OE well dressed good eye contact, normal speech, linear thought. blunted affect. No SI*	Exhibit P-000092 [page 7]

	Impression: Likely does have PTSD given story *Plan: Need old chart from Ste. Anne's Hospital – will request* *has enough medications for now* *In event of crisis has contracted to come back here or go to ED for help"* Dr. Harnish reviewed Lionel Desmond's medical record from the Guysborough Medical Clinic but it contained no record of his treatment related to his PTSD. Dr. Harnish was not familiar with Ste. Anne's Hospital in Montreal and he, Lionel and Shanna Desmond had to do an internet search to find information about the facility. Dr. Harnish was unable to access any records relating to the treatment given to Lionel Desmond in Montreal or at the New Brunswick OSI Clinic. He was only able to determine his medications as Mr. Desmond had them with him in a shopping bag.	 Transcript March 10, 2021 [pages 147 – 151]
October 14, 2016	Over two (2) months have passed since Lionel Desmond left the Ste. Anne's Stabilization and Residential Program. Lionel Desmond has called Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette several times over the past week. He is not coping well and reports being under pressure/stress relating to his "living situation" and "personal life." Highlights from Ms. Doucette's progress note include: *a. "Multiple conversations with veteran this week due to some difficulties in his living situation / personal life. CM and him discussed a plan to keep himself occupied and as calm as possible until CCM is ready to engage with him (BHSOL training scheduled for OCtober* [sic] *27)."* *b. "CM researched options for psychologists in his area and provided three options for him to look into. Also, reminded him of VAC Assistance service to use in the short term if he feels it is needed."* *c. "Plans to reconnect via phone upon CM's return to the office week of Oct. 24 and establish list of priorities for work with CCM. Veteran was in agreement."* It is notable that since he has returned to the community setting Lionel Desmond has lacked the necessary supports for his well-being. He is without a family physician, peer support network, occupational therapist, therapist, and psychiatry services (outside of an emergency room setting).	Exhibit P-000117 [page 8]

	Lionel Desmond left Ste. Anne's Hospital on August 15, 2016, without ever having achieved stabilization. He was unable to begin trauma therapy. Now while in the community he is directly interfacing with the prominent stressors which are marital discord, finances, and isolation. He navigates these stressors alone. A clinical case manager has yet to be assigned and no arrangements have been made for the recommended neuropsychological assessment. Timely treatment and interventions are desperately needed. However, Veterans Affairs Canada (VAC) is nowhere near the implementation stage or in a position to coordinate the recommended services in a shared Ste. Anne's report.	
October 14, 2016	Two (2) months have passed since Veterans Affairs Canada (VAC) identified Helen Boone as the appropriate professional to serve as Lionel Desmond's clinical care manager. Meanwhile Lionel Desmond continues to have difficulties in his "living situation" and "personal life." Interestingly, these are exactly two (2) areas where a clinical care manager is specifically equipped to assist. Nevertheless, Ms. Boone is unable to begin her work due to the insistence of Veterans Affairs Canada (VAC) that BHSOL training be completed. The first opportunity for BHSOL training does not become available until October 27, 2016. Ms. Boone testified that the need to have her trained on the BHSOL system was "within the first conversation or two" with Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette. Furthermore, Ms. Boone testified to the early frustrations surrounding the delay in the BHSOL training as of October 14, 2016. a. *"**A.** … Ms. Doucette and I had a number of conversations about it. She was anxious for me to get working with the client was the perception that I got. I was ready to move on and engaging with the client, and we were not having success in getting the opportunity for me to be trained.* ***Q.** And what was standing in the way? What was the problem?* ***A.** I'm not sure. From my understanding of the conversations that I was having with Ms. Doucette, she had*	Exhibit P-000117 [page 8] Transcript April 21, 2021 [page 38] Transcript April 21, 2021 [page 39]

		tried numerous times. She was sending emails. That's what she had told me." b. *"**A.** I think I recall like there was some issues. I don't recall the specifics of the issues that were getting in the way from them getting the training done or sending me the invite for getting the training done, but it didn't happen, and they were saying that I could not see the client until I got trained for it, so that was an issue until Ms. Doucette said, You know what? We're going to have to go ahead and just do this."*	Transcript April 21, 2021 [page 44]
Oct. 18,	**2016**	Dr. Murgatroyd contacts the Nova Scotia OSI Clinic in relation to the September 30, 2016, inter-clinic referral. He is advised by Nurse Natasha Tofflemire that Lionel Desmond will not be accessing the valuable resources of the Nova Scotia OSI Clinic. The following notations are made by Dr. Murgatroyd: *"The writer spoke with OSI nurse, Natasha, who confirmed she contacted Mr. Desmond to complete a triage. She indicated that, at this time, Mr. Desmond has a therapist in the community and that he would also be connected for psychiatric services in the community."* *"Writer had a brief chat with Mr. Desmond. He said he is in the process of being assigned a family doctor."* *"Mr. Desmond confirmed that the OSIC in Halifax contacted him and that, at this time, he would prefer accessing community resources than have to travel to Halifax."* *"He does not yet have a local therapist, but this will be discussed with his CM once she gets back from her vacation. He will also be looking at getting connected to see psychiatry in Antigonish, NS."*	Exhibit P-000244 [page 42]
October 18, 2016		Dr. Murgatroyd from the New Brunswick OSI Clinic makes an entry in the running log regarding a contact with the Nova Scotia OSI Clinic: *"The writer contacted the OSIC in Halifax to follow-up on the inter-clinic referral that was sent a few weeks back regarding Mr. Desmond. The writer spoke with OSI nurse, Natasha, who confirmed she contacted Mr. Desmond to complete a triage. She indicated*	Exhibit P-000244 [page 42]

	that, at this time, Mr. Desmond has a therapist in the community and that he would also be connected for psychiatric services in the community. At this time, it appears he has remained with his VAC CM, in NB, Marie-Paule Doucette." Natasha Tofflemire did not recall this conversation. She speculated that there may have been miscommunication between herself and Dr. Murgatroyd. She did not recall any further communication related to Lionel Desmond's file.	 Transcript March 9, 2021 [pages 122 and 129 - 130]
October 24, 2016	Lionel Desmond attends at the Outpatient Department of St. Martha's Regional Hospital in Antigonish at 12:40 p.m. and is seen by Dr. Ian Slayter and Heather Wheaton, a mental health nurse. Dr. Slayter is a general adult psychiatrist. He works at the Outpatient Department and Emergency Department of St. Martha's Regional Hospital in Antigonish. This was the first occasion that Dr. Slayter met Lionel Desmond. In the Emergency Triage Record he was described as being in a situational crisis. A Crisis Response Service Mental Health/Risk Assessment is completed by Mental Health Nurse Heather Wheaton. Ms. Wheaton's description of Lionel Desmond was as follows: *"32 yr old Male (Black) Slightly unkempt in sweat clothes. Angry outbursts that occur suddenly and are followed by return to low mood - Anxiety - Paranoid thoughts about wife. General distrust of all People - feeling tired and overwhelmed and unsure about how to best get or receive help. Suicidal Ideation Ø intent or Plan. Affect downcast and speech is tangential - wants to talk about his Military experiences."* Lionel Desmond was accompanied by his wife Shanna. Both were described by Dr. Slayter as being emotional. Lionel Desmond's main complaint was that he was having trouble sleeping because of nightmares and was experiencing PTSD symptoms such as flashbacks and nightmares. Dr. Slayter also observes "that there was a lot of arguing going on between them." His nightmares related to his military experience and that his wife had been cheating on him. His main complaint on that day was his inability to sleep.	Exhibit P-000067 [pages 7 – 10] Exhibit P-000067 [page 9] Transcript February 10, 2020 [page 33]

	The meeting lasted approximately 15-30 minutes. Lionel Desmond's demeanour was described as subdued. During the conversation it was disclosed to Dr. Slayter that Lionel Desmond "would get angry at times and sort of pound tables." His prescribed medications at that time were Quetiapine, Zolpidem and Prazosin. Dr. Slayter prescribed Trazodone. In the notes of Ms. Wheaton it was noted that, "Trouble navigating Veteran's [*sic*] Affairs System and worries about what they will offer + what they will cover - Waiting for a Vet Affairs case manager in N.S. Transfer not complete." His suicide risk was assessed as low by Dr. Slayter. In terms of follow-up, Dr. Slayter said the following: *"I said to him that I thought he needed services and I was concerned when he said that he was waiting for services to be set up in Cape Breton my expectations that that was going to happen soon were pretty poor, so I thought that he should be followed by somebody. So I said to him that if he . . . he was expecting a phone call or something from them I think a couple of days later, and I said that if services weren't going to start very quickly then I would be happy to see him again to dig deeper into what was going on and look at what we could do to help him as a cover up, not a cover up, to cover until he was picked up by OSI …"*	Transcript February 10, 2020 [page 37] Exhibit P-000067 [page 8] Transcript February 10, 2020 [page 48]
October 27, 2016	Social Worker Helen Boone attempts to complete the online BHSOL training. There is a power outage. Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette is not authorized to reschedule the training. As a result, it is put on hold until another Veterans Affairs Canada (VAC) representative contacts Ms. Boone.	
November 2, 2016	Lionel Desmond has an appointment at the Guysborough Medical Clinic to see Dr. Mahendrarajah. As she is running late in the Emergency Department of the Guysborough Memorial Hospital, Mr. Desmond is sent to see her there. He is seen at 6:15 p.m. Lionel Desmond asked to be seen as he continued to suffer the symptoms of his PTSD, including flashbacks and dreams that interfered with his sleep. She did not find him to be in acute distress on this occasion. Dr. Mahendrarajah was told by Mr.	Exhibit P-000092 [pages 9 – 10] Transcript March 9, 2021 [pages 44 – 58]

	Desmond that he had seen Dr. Ian Slayter and that he had been started on new medications. She planned to make another referral to Dr. Slayter. Dr. Mahendrarajah did not have access to any of Mr. Desmond's medical records from the Canadian Armed Forces (CAF), New Brunswick OSI or Ste. Anne's Hospital. She did not know about his relationship with Veterans Affairs Canada (VAC) or if he had a case manager. Dr. Mahendrarajah made the referral to Dr. Slayter by way of referral letter dated November 2, 2016.	
November 2, 2016	Dr. Ranjini Mahendrarajah makes a referral for Lionel Desmond to be seen again by Dr. Slayter. The referral is faxed on November 3, 2016.	Exhibit P-000067 [pages 13 and 21]
November 4, 2016	Three (3) weeks have passed since Lionel Desmond has had contact with his Veterans Affairs Canada (VAC) case manager. He phones looking to speak to her and is put through to her voicemail.	Exhibit P-000273 [page 7]
Nov. 7, 2016	Almost three (3) months since Lionel Desmond's leaving Ste. Anne's, Veterans Affairs Canada (VAC) has yet to allow Social Worker Helen Boone to begin her work as his clinical care manager. The BHSOL training has yet to be completed. Ms. Doucette's progress note reads: a. *"Phone communication with Social Worker Helen Boone. She informed CM that she had started her training at the end of October as planned and midway through the online session, there was a power outage at her office. The trainer / VAC representative for BHSOL had advsied* [sic] *someone would be in touch to schedule a new time."* b. *"CM expressed there was some urgency to this training being completed and is now awaiting a reply. Ms. Bonne* [sic] *confirmed this morning she remains interested and available to work with the veteran."*	Exhibit P-000117 [page 7]
November 7, 2016	In a further system entry from this date Ms. Doucette again flags the urgency of the situation. There is an urgency in structuring Lionel Desmond's continuity of care now that he has been out of Ste. Anne's for almost three (3) months and residing in rural Nova Scotia.	

	He is more vulnerable than ever and at risk of further deterioration. It is unfortunate that despite such urgency he has remained in rural Nova Scotia for months waiting for supports. Coordination of these supports will remain lacking in the last two (2) months leading up to the January 3, 2017, tragedy. Ms. Doucette's system entry reads: *"He immediately relocated to another province as his NB home sold while he was in treatment. As a result of the move, he requires new support / providers in his area of Nova Scotia. Given ongoing concerns expressed by the team of professionals at Ste. Anne's hospital at the time of his release, the veteran is believed to be in need of help to organize his services and find stability after being away from his home province for many years."* In a late system entry made by Ms. Doucette on the date of the tragedy (January 3, 2017) she lists what are supposed to be the desired outcomes of the Veterans Affairs Canada (VAC) case plan. Timely and effective coordinated interventions aimed at increasing Lionel Desmond's stability in rural Nova Scotia did not happen. The post-tragedy system entry reads: *"Over the next six months, the veteran will find greater stability in his new geographical location, including new community resources. The veteran will have achieved increased stability once he is settled in a more permanent residence and is engaging with his new supports on a regular basis (minimum bi-weekly interaction with at least one helper). Progress will be monitored via CM's communication with veteran and service providers."*	Exhibit P-000117 [page 4] Exhibit P-000117 [page 1]
November 7, 2016	Cathrine Chambers is a registered counselling therapist. She has a master's degree in education and counselling (Acadia University 2007). She is currently self-employed and offers trauma and anxiety therapy from her clinic in Antigonish. She has been offering counselling services since 2007 and her clients have included: first responders, healthcare professionals, fire, police, ambulance, veterans, and survivors of sexual violence. She estimates that over her career she has treated approximately 50 soldiers or veterans who have been diagnosed with PTSD. On this date Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette contacts Cathrine Chambers for the first time. A Veterans Affairs Canada (VAC) referral is made for "community-based psychotherapy." Ms. Chambers testified to the details of this initial November 7, 2016, conversation:	Exhibit P-000073 Transcript February 12, 2020 [page 126]

	1. *"She said that she had a veteran who needed some psychotherapy, community-based psychotherapy for a PTSD diagnosis, and she was waiting, I believe, to get a consent form signed so that she could give me the details of the case."*	Transcript February 12, 2020 [page 142]
	2. *"I believe after she got the release from Mr. Desmond that she was able to tell me that he had been in an inpatient treatment program in Quebec, and the information that was shared with me at the time was that it wasn't particularly helpful, that he had just recently moved to Nova Scotia and needed treatment for PTSD."*	Transcript February 12, 2020 [pages 143 – 144]
	Ms. Chambers further testified that Ms. Doucette provided her with very few details about Lionel Desmond's extensive medical history. She was only told that Lionel Desmond had been diagnosed with PTSD, that he had attended the New Brunswick OSI Clinic and the Ste. Anne's Residential/Stabilization Program. Ms. Chambers did not receive medical records, summaries, or particulars surrounding Lionel Desmond's symptoms, treatments, stressors, and psychosocial history. It should also be noted that at no point did Ms. Chambers ever request that Veterans Affairs Canada (VAC) provide her with more information. In particular, she did not initiate a request for any historical reports relating to Lionel Desmond's medical or psychological history. However, despite this, she testified:	
	"Yes, based on the information that he shared with me and that the case manager shared with me, yes, I thought that he would be a good candidate for treatment with me."	Transcript February 12, 2020 [page 147]
	Also, on this date Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette makes her first contact with Antigonish Therapist Cathrine Chambers.	Exhibit P-000117 [page 7]
	In her progress note Ms. Doucette originally refers to Cathrine Chambers as a psychologist. Ms. Chambers lacks such qualifications and is a registered therapist. It is notable that during Lionel Desmond's involvement with the New Brunswick OSI Clinic and the Ste. Anne's program he had been assigned psychologists (Dr. Murgatroyd and Dr. Isabelle Gagnon). Ms. Doucette originally documents Cathrine Chambers as a psychologist who "works with many veterans, and specializes in Trauma / PTSD work." A portion of Ms. Doucette's progress note reads:	

"Phone communication with Psychologist Cathrine Chambers of antigonish [*sic*] *NS (provider recommended by NS colleague). She confirmed she has availability for new clients at this time, works with many veterans, and specializes in Trauma / PTSD work. Without providing any information through which veteran could be identified, CM and psychologist came to the following agreement: Veteran will be asked to be touch* [*sic*] *with her to set up a first informal appointment. Once that is confirmed, CM will send consent forms to her office for veteran to sign (Psychologist can keep a copy for herself if needed) and return. Once they are returned, CM can provide psychologist with some information that is relevamt* [*sic*] *to veteran's psychological health. No new psych assessment needed at this time."*

Veterans Affairs Canada (VAC) never did send these consents to Cathrine Chambers.

At the time of retaining Therapist Cathrine Chambers, Ms. Doucette is in possession of the August 17, 2016, Ste. Anne's Interdisciplinary Discharge Summary which was received October 7, 2016. She is also aware that those professionals have recommended at least two (2) very significant assessments. Both the neuropsychological assessment and occupational therapy/functional assessment are needed to determine the actual cognitive capacity of Lionel Desmond. Trauma treatment cannot be tailored specifically to Lionel Desmond without first knowing the results of such testing. This knowledge and information are not shared with Therapist Cathrine Chambers.

The following material documents are in the possession of Veterans Affairs Canada (VAC) and not shared with Therapist Cathrine Chambers.

1. May 25, 2015, Canadian Armed Forces (CAF) Transition Interview Report (8 pages)
2. August 17, 2016, Ste. Anne's Interdisciplinary Discharge Summary (8 pages)
3. December 15, 2015, Ste. Anne's referral from New Brunswick OSI with supporting psychiatry report from Dr. Anthony Njoku
4. Case Plan documents and Case Plan reports
5. January 5, 2016, Area Counsellor Client-Centred Assessment (10 pages)

	6. Various Canadian Armed Forces (CAF) nursing reports in the possession of Veterans Affairs Canada (VAC) At the Inquiry Ms. Doucette was asked about the possibility of sharing such records with Therapist Cathrine Chambers. Ms. Doucette testified: *"**Q.** In terms of Mr. Desmond and Ms. Chambers starting that relationship, did you provide any documents to Ms. Chambers?* ***A.** No, not right off the bat. I recall a conversation where I sort of, you know, asked how she wishes to proceed with new clients. It's really not a case manager's place to tell a professional how to run their practice and I remember . . . a detail that I remember speaking to her. Now I don't know if that was the first time we spoke or in a follow-up saying to her that we had recent assessments completed on file so if that was ever helpful to her, then she can definitely request and obtain the veteran's consent for some of that information to be shared. So there was never sort of any withholding of information but we don't just freely share things without the veteran's consent. So I believe in the end what happened was that she decided to meet the veteran and do her own sort of form of assessment and then would return with questions if there were any."* More generally, Ms. Doucette further testified to her understanding of a veteran's medical records within the Veterans Affairs Canada (VAC) structure: a. *"So I don't consider or understand VAC to be sort of a keeper of medical information. Like it's not a place where everything gets turned over. Some medical information or psychological information will come to us by way of program participation or, like in the rehab programs, for example, which is what I'm most familiar with, we will have summary reports, recommendations from professionals. That sort of stuff. And that goes on their file but it's not . . . like, one, it's not information that belongs to me as a case manager or a VAC employee. It's really evidence on the veteran's file."* b. *"And they're aware of that generally, that if they ever want to access something on their file, that there's a process that they can go through to obtain that. And it's happened before. I've had some veterans request some aspects of their file.*	Transcript June 22, 2021 [pages 185 - 186] Transcript June 22, 2021 [pages 204 – 205]

		But, yeah. Not a keeper of medical records by any means."	
November 22, 2016		Given the considerable three (3) month delay in the ability of Veterans Affairs Canada (VAC) to coordinate the BHSOL training, Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette decides it is now best that Social Worker Helen Boone proceed with her work with Lionel Desmond. Ms. Doucette's progress note from this date reads: *"CM also advised veteran of the hiccups regarding CCM's online training with VAC. There will be a new attempt to complete training this week. CCM, Helen Boone, indicated she could schedule to meet with veteran for the first time Friday December 2. Veteran said he could make himself available that day and will expect a call from her. CM communicated info back to Ms. Boone and asked that she confirm with CM once they have set up at* [*sic*] *time to meet."* It is worth noting that Ms. Boone never did get the rescheduled BHSOL training until January 23, 2017. This was three (3) weeks after the Desmond tragedy.	 Exhibit P-000117 [page 7]
Nov. 22,	**2016**	Therapist Cathrine Chambers contacted Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette. She has not yet heard from Lionel Desmond. As well, Helen Boone is still not authorized by Veterans Affairs Canada (VAC) to begin work with Lionel Desmond. Highlights from Ms. Doucette's progress note include: a. *"Call received from Cathrine Chambers, Counselor based out of Antigonish NS. She simply wanted to advise CM she has not heard from veteran who was to call her. CM therefore called veteran back. He stated he had received her message and apologized fornot* [*sic*] *following up. CM saind* [*sic*] *no need to apologize, yet reminded him that a counselor was ready and willing to work with him. Ms. Chambers' phone number was provided a second time and veteran committed to calling her."* b. *"CM also advised veteran of the hiccups regarding CCM's online training with VAC. There will be a new attempt to complete training this week. CCM, Helen Boone, indicated she could schedule to meet with veteran for the first time*	Exhibit P-000117 [page 7]

	Friday December 2. Veteran said he could make himself available that day and will expect a call from her."	
November 25, 2016 **7:49 p.m.**	RCMP Investigation File # 20161560270 On November 25, 2016, Cst. O'Blenis was acting as supervising officer. Cst. Burns Anderson was the assigned officer. Lionel Desmond had phoned the NS Guysborough RCMP stating that his wife is overdue to return home and that he is packing his bags. He advised she kicked him out and their marriage was over. No RCMP action was taken and the report noted: *"No need for police.Shanna* [*sic*] *was fine."* Despite the known history and the RCMP involvement of November 28, 2015, this occurrence did not generate a Firearms Interest to Police (FIP) entry/designation. This occurrence was never shared with either the CFO for Nova Scotia or the CFO for New Brunswick.	Exhibit P-000086 CAN001824
November 30, 2016	This is the last time Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette will communicate with Lionel Desmond. After a three and a half (3 ½) month delay Social Worker Helen Boone and Lionel Desmond meet for the first time. During this meeting they make a call to Ms. Doucette. Ms. Doucette's progress note reads: a. *"… received a call, as planned, from CCM and veteran today as they engaged in their first face-to-face meeting. Writer reviewed priorities to address via CCM services; priorities that were mutually set with the veteran in a recent phone call. Veteran and CCM appeared to be satisfied with this list as a good starting point. Writer hung up so they could carry on with their initial meeting and figure out next steps."*	Exhibit P-000117 [page 6]
November 30, 2016	During this three-way call Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette is aware Lionel Desmond and newly retained Clinical Care Manager Helen Boone have started the process of identifying his rehabilitation needs and immediate priorities. Despite this awareness Ms. Doucette does not alert Ms. Boone to the fact that Veterans Affairs Canada (VAC) is in possession of important documentation as it relates to the very rehabilitative	

	needs and priorities she is trying to assess. One (1) such critical document is the Ste. Anne's Interdisciplinary Discharge Summary report that was faxed to Veterans Affairs Canada (VAC) on October 7, 2016.	
	*"**Q.** And you were waiting on what to give her the report after the three-way?* ***A.** I'm not sure that I was waiting on anything. So if we can pause and talk about consent and what is shared. I've said this before in my testimony, I would rarely take someone else's full report, like in very exceptional circumstances, and share it freely with another provider when it's not something that I've authored."* *So if it was Mr. Desmond wanting to share it and he was signing that consent that's one thing, but the Ste. Anne's report doesn't belong to me. So in this instant we decided to do the work over the phone, she was taking notes, that's as much as I can tell you right now.* *So I don't recall if I had a specific plan to send her that report but I don't believe that's . . . I don't have . . . I don't do that as a common practice unless it's something that I authored and I feel like it's okay to share."*	Transcript June 23, 2021 [pages 266 – 267]
November 30, 2016	Social Worker Helen Boone meets with Lionel Desmond for the first time. This meeting lasts approximately three (3) hours. During this meeting Ms. Boone describes Lionel Desmond as initially "uncomfortable," "quiet," "reserved," "friendly," "fidgety," and "wasn't making eye contact." He becomes more relaxed as the meeting progresses. Ms. Boone testified in detail about her initial impressions of Lionel Desmond's circumstances and the degree of interventions needed. a. *"He presented as somebody who was very open and eager to get support."*	Transcript April 21, 2021 [page 51]
	b. *"He definitely presented as somebody who was motivated for self-improvement. At times, he seemed very overwhelmed with where to start. He was somebody that spoke so highly of his daughter and his role of being a father. He spoke about the challenges he has with his mental illness and how that's*	Transcript April 21, 2021 [page 52]

impacting on his relationship with his wife and he indicated that he was willing to do whatever it takes to work on this."

c. *"I got a sense that this certainly would not be a brief intervention ..."*

Transcript April 21, 2021 [page 57]

d. *"And from that meeting, again, it was one meeting, at that time, but I certainly got the sense that this would take time."*

Transcript April 21, 2021 [page 58]

During this first meeting Ms. Boone identified several areas where Lionel Desmond will immediately need community "wrap around" care. These areas included:

Transcript April 21, 2021 [page 57]

Exhibit P-000288 [page 5]

1. Exercise/gym membership
2. Occupational therapy assessment
3. Peer support
4. Housing
5. Relationship counselling
6. "Men's Health issues"/resources
7. Addictions services
8. Psychotherapy

Ms. Boone testified what Lionel Desmond actually told her about the current status of his relationship with Shanna Desmond and the need for relationship counselling.

Transcript April 21, 2021 [pages 80 – 83]

a. *"That's one of the things that Lionel had asked for was relationship counseling to work on marital issues for reintegrating back into the family life. And his wife, he said, was asking for relationship counseling, so he wanted to follow up on what . . . on his wife's request for relationship counseling."*

b. *"Yes. That was one of the requests that he had. He was asking for relationship counseling and in terms of he indicated that his wife really wanted them to have counseling and he was interested. And he thought that could be positive for their relationship."*

c. *"Well, he told me that with him being away for so long, it was extremely challenging on their relationship because when they spent time together it was always for short periods of time. It wasn't for extended periods of being able to live together again. And he had said that she got*

	used to raising their daughter on her own so he felt sometimes like an outsider. And she would say, Well, I'm used to doing this. So that they kind of needed some help for being able to communicate some of these things with each other in a more positive way, being able to navigate where their roles were in the relationship." d. *"He was also concerned that, you know, Is this something that she even wants? But she indicated that she does want to work on trying to get things back together again. And he said that he felt like he was trying to do everything he possibly could to make sure that she was happy in the relationship. So he did tell me that they had some financial troubles because they sold the home and then he indicated to me that he used the proceeds from the sale of the home to pay off debts and also to make sure that her education was paid for."* e. *"He said that she was either finishing up or just finished up her Nursing degree and that was very expensive. And they paid for all that, but he had hopes that once she was working then between his pension and her income that in a couple of years they would be in a much better position financially because their debts were paid. But they needed to find something affordable in the meantime. So it was all information that he had provided to me about their relationship."* f. *"He did say that their relationship had been, you know, rocky and strenuous at times. He didn't tell me that she wanted to divorce him. He said that she wanted to work on the marriage and that's why he was seeking relationship counseling."*	
December 1, 2016	Lionel Desmond attends the Emergency Department of St. Martha's Regional Hospital and is registered at 11:28 a.m. He is alone. Ellen MacDonald, a registered nurse, conducts the triage. His stated reason for attending on that day as it is recorded on the chart is: *"LOOKING TO SPEAK TO SOMEONE IN MENTAL HEALTH-PROBLEMS WITH HOME LIFE,ANGER ISSUES.HE AND HIS WIFE ARE HAVING PERSONAL RELATIONSHIP PROBLEMS.FREQUENT OUTBURSTS AT*	Exhibit P-000067 [page 22]

	HOME AND IN A TEMPORARY SEPARATION.SEES DR. SLAYTER-LAST SAW 6 WEEKS AGO.WANTS TO SEE SOMEONE IN MENTAL HEALTH." At 15:10, the chart note completed by RN Amy Collins indicates that Lionel Desmond was no longer in the waiting area. The practice at the Emergency Department at St. Martha's Regional Hospital at that time was that if an individual had not been seen, the doctor on call in the Emergency Department the next day would determine if they required a call back. However, in this case, the file chart indicates that no follow-up call was ordered.	Transcript February 12, 2020 [pages 28 – 29]
December 2, 2016	Lionel Desmond attends for his first scheduled appointment with Therapist Cathrine Chambers. Ms. Chambers testified that there was no sense of urgency communicated to her with respect to scheduling Lionel Desmond for the initial appointment. The plan for this first session was to begin the "assessment phase." Ms. Chambers anticipated this would take at least three (3) to six (6) separate sessions/appointments. In describing this assessment phase Ms. Chambers stated: a. *"Yes. So there's an assessment period, which can be, typically, anywhere from three to six sessions, and that's a really exploratory approach where, during that time, I'm looking to hear from the person about a wide variety of domains in their life. I am talking to them about what they experience on the inside - do they experience anxiety, panic attacks, depression, what does the depression look like, what kinds of thoughts come."* b. *"You know, typically, there are sort of what we call cognitive distortions, a person might see things in black and white, all or nothing, they might, you know, discount the positive and only focus on the negative. That's quite typical for depression, so I'm looking for things like that. I'm looking to see what kinds of symptoms they're experiencing, what's happening with their sleep, what's happening in their workplace, what's happening in their relationships, what kinds of relationships do they have, are they relations that feel safe, is there conflict in those relationships, how does the person deal with that kind of conflict."*	Transcript February 12, 2020 [pages 150 – 151] Transcript February 12, 2020 [pages 127 – 128]

	c. *"I'm looking at their kind of external environment, what kinds of supports they have in place. I'm not talking too much in the very beginning about specific details related to the trauma because, again, we're really working in the beginning to try to regulate the nervous system and help the person be able to access feelings of calm and safety in the body and also in the external environment. Recounting, you know, details of the trauma, the research is pretty clear on that now that that just re-traumatizes people. So I'll get a broad sense of, you know, what they're struggling with, but we don't really look at addressing specific traumatic memories until later in treatment."*	
	It was clear that it was going to take considerable time before Ms. Chambers could effectively build a therapeutic foundation with Lionel Desmond. During this first 50 to 60-minute session Ms. Chambers concluded that due to Lionel Desmond's level of complexity, the assessment phase alone was going to take "at minimum six sessions."	Transcript February 12, 2020 [page 158]
	During the brief course of her involvement with Lionel Desmond between December 2, 2016, and January 3, 2017, Ms. Chambers was unaware that he had been assessed by Psychiatrist Dr. Ian Slayter. Interestingly, when Lionel Desmond attends his first meeting with her on December 2, 2016, she had no idea he had actually met with Dr. Slayter earlier that same day. Mr. Desmond never mentions this earlier appointment to her nor does she have any way of knowing about it. Again, important information is not communicated. Dr. Slayter's note from December 2, 2016, reads as follows:	
	"He needs intensive psychotherapy for the PTSD and jealously regarding his wife. He is seeing a new therapist today in Antigonish. I do not know whether she provides the type and level of therapy needed for PTSD. She should be able to help him work on the jealously issues."	Exhibit P-000067 [page 28]
	Ms. Chambers testified that it would have been important for her to know that Lionel Desmond had long-standing jealously directed towards Shanna Desmond coupled with the frequent dreams/thoughts of harming her. She testified that had she been aware of both she would have given it priority at the outset and within the assessment phase. She testified she could have coordinated specific and targeted interventions.	Transcript February 13, 2020 [pages 83 – 85]

December 2, 2016	Lionel Desmond is seen by Dr. Ian Slayter at St. Martha's Regional Hospital Outpatient Department. The visit on this occasion was scheduled to last two (2) hours. On this occasion Lionel Desmond is alone. Dr. Slayter described him as "quite complex in terms of a number of different problems." Dr. Slayter described his presentation as follows in the Mental Status Examination of his reporting letter: *"He presented today as a present, depressed man who was calm and appropriate. Rapport fair. Affect depressed. Speech articulate and normal in rate and amount. Thought process coherent and rational. He reported thoughts of jealousy which seemed to me overvalued and bordering on delusional. Cognitive difficulties were evident in that he reported difficulties with information processing and said during the interview with me that he missed and could not retain many of the words I was saying. Insight fair."* The symptoms Lionel Desmond described to Dr. Slayter included flashbacks, nightmares, anxiety, high alert, depression, difficulty coping with noise and avoidance, all symptoms consistent with his diagnosis of PTSD. According to Dr. Slayter, Lionel Desmond reported low mood, low appetite with weight loss, poor sleep, low energy, low enjoyment, low libido and poor concentration – all consistent with his diagnosis of major depression. Dr. Slayter diagnoses Lionel Desmond with the following conditions and makes the following assessment: "● *Major Depression* ● *Post-Traumatic Stress Disorder (PTSD)* ● *Post-Traumatic Brain Disorder* ● *Borderline Delusions re Wife* ● *R/O Attention Deficit Disorder (ADD)* ● *Suicide Risk–low"* Dr. Slayter also noted that Lionel Desmond had three (3) falls with head injuries while serving in the military. He suspected that Lionel Desmond had suffered concussions. Dr. Slayter felt that a neurocognitive assessment would be beneficial for him. Such	Exhibit P-000067 [pages 26 – 28] Transcript February 10, 2020 [page 52] Exhibit P-000067 [page 27]

	assessments were not available in this area of Nova Scotia according to Dr. Slayter.	
	Dr. Slayter was unable to access any medical records for Lionel Desmond. He was unable to access any medical record related to his time in the Canadian Armed Forces (CAF). Lionel Desmond was unable to provide any medical records relating to his treatment since his release from the Canadian Armed Forces (CAF). Dr. Slayter stated he "had no idea how to get them."	Transcript February 10, 2020 [page 99]
	Dr. Slayter made the following observations and recommendations: *"He would benefit from, and deserves, an intensive treatment and rehabilitation program. Such is not available in rural Nova Scotia. I advised him to contact OSI Halifax as I think he needs to be followed by them or a similar service.* *I did not have time to fully review his response to his present medications. They help only a little. It is striking that he is not on an antidepressant despite being depressed. He tells me that he has been treated with several antidepressants but cannot remember the names and says they did not help. I asked him to obtain his military medical records so that I can review his medication history before considering medication changes or additions.* *. . .* *He needs intensive psychotherapy for the PTSD and jealousy regarding his wife. He is seeing a new therapist today in Antigonish. I do not know whether she provides the type and level of therapy needed for PTSD. She should be able to help him work on the jealousy issues.* *He would benefit from a neuropsychological assessment regarding his cognitive deficits and dysfunctions which I think relate to the concussions. Cognitive rehabilitation should then be sought. Again, services of this sort are not available locally.* *I advised him to get his military medical records as noted above.* *I encouraged him to participate regularly in a gym and in yoga both of which he has found helpful in the past but which he cannot afford at present. I gave him a note today advising that he would benefit from funding for a gym membership and yoga training."*	Exhibit P-000067 [page 28]

	And in conclusion, stated: ***"I would normally see someone with PTSD once only to confirm the diagnosis and make recommendations. However, given the complexity of his case, and given that he seems to be falling through the cracks in terms of follow-up by military and veteran programs, I said I would follow him for a short while to help him get connected. I shall focus on treatment in subsequent sessions rather than on further elucidation of the details of his disorders as that needs to be done by others at a higher level of service."*** [Emphasis added] Dr. Slayter stated the following: *"Well, I thought he needed more trauma therapy and needed . . . it would . . . I felt bad for him. He was, seemed to me, been let go of what he had been getting and wasn't getting and he was having a hard time and his wife was having a hard time. And I thought that he's put his life on the line for people, that he deserved to get the full service that the military, the veterans . . . could provide."* Dr. Slayter asks Lionel Desmond to make a follow-up appointment in two (2) to four (4) weeks.	Transcript February 10, 2020 [pages 90 - 91]
December 9, 2016 #1	Despite Therapist Cathrine Chambers' desire to meet with Lionel Desmond on a weekly basis, he misses his second appointment with her. He sends her a text message later in the morning on December 9, 2016, indicating that he "slept in" and was feeling "a bit drowsy."	Exhibit P-000077
December 9, 2016 #2	Social Worker Helen Boone and Lionel Desmond meet for the second time. This meeting lasts for approximately one (1) hour and Lionel Desmond is described as being more relaxed. Both parties agree that a referral to Family Service of Eastern Nova Scotia (FSENS) would assist in his rehabilitation. Lionel Desmond signs a consent which authorizes Ms. Boone and Family Service of Eastern Nova Scotia (FSENS) to share information back and forth regarding his background, treatments, struggles, and progress. Ms. Boone testified that Family Service of Eastern Nova Scotia (FSENS) could offer several valuable supports for Lionel Desmond. In her words these supports were "twofold." First, they could offer couples counselling. Second, they offered services through the	Exhibit P-000288 [page 3] Transcript April 21, 2021 [pages 86 - 87]

	Men's Health Centre in Antigonish. These services would have included: a. "various types of screening that is specific to males" b. "opportunities for socialization" c. "parenting groups" d. "things that he had identified as very important to him in our first conversation" Unfortunately, all of these resources never had time to be implemented. Naturally, had Ms. Boone been retained at the earliest opportunity, these connections would have been established and well underway on December 9, 2016. Ms. Boone testified: a. *"Yes. And I would say that, with any client, earlier intervention always means better success."* b. *"It's always hard looking back but certainly I would maintain my earlier suggestion that earlier intervention typically means more success for individuals. And I think that is true for most cases. And I believe it is true for Lionel's case that early intervention and the necessary support is important for successful transition."* In addition, Lionel Desmond readily agrees to sign a second consent to release information. This second consent was sent by Veterans Affairs Canada (VAC) to Helen Boone. It was drafted by Veterans Affairs Canada (VAC) and authorizes them to collect information from third parties about Lionel Desmond "to support the administration of VAC benefits or services." Interestingly, this is a single flow of authorized sharing of information. Veterans Affairs Canada (VAC) has requested that Lionel Desmond sign a consent allowing Ms. Boone to share her information with them, however, there is no such consent flowing the other way. Veterans Affairs Canada (VAC) never did send Ms. Boone a consent for Lionel Desmond to sign which would have allowed them to share with Ms. Boone documents and information they had in their possession. Similar to Therapist Cathrine Chambers, Ms. Boone never has access to critical information contained within the following documents:	Transcript April 21, 2021 [page 90] Transcript April 21, 2021 [page 92] Exhibit P-000288 [page 4]

a. May 25, 2015, Canadian Armed Forces (CAF) Transition Interview Report (8 pages)
b. August 17, 2016, Ste. Anne's Interdisciplinary Discharge Summary (8 pages)
c. December 15, 2015, Ste. Anne's referral from New Brunswick OSI with supporting psychiatry report from Dr. Anthony Njoku
d. Case Plan documents and Case Plan reports
e. January 5, 2016, Area Counsellor Client-Centred Assessment (10 pages)
f. Various Canadian Armed Forces (CAF) nursing reports in the possession of Veterans Affairs Canada (VAC)

Ms. Boone did not receive medical records, summaries, or particulars surrounding Lionel Desmond's symptoms, treatments, stressors, and psychosocial history prior to her being retained.

Over the course of her two (2) meetings with Lionel Desmond, Ms. Boone identifies many interventions which need to be given immediate priority. Ms. Boone documents these in her Clinical Care Manager (CCM) - Outcomes Agreement. The "**Mutually Identified Needs**" include:

Exhibit P-000283 [page 1]

1. "Ongoing needs assessment"
2. "Daily/weekly telephone contact"
3. "Expand social network"
4. "Other - specify OT Assessment"
5. "Plan for activities of daily living"
6. "Housing or vocational support"
7. "Practical assistance"
8. "Other - specify couples counselling"

Ms. Boone proceeds to identify what she views as "**Desired outcome No. 1**." This top priority is noted as:

"Assist veteran with re-engagement with family and also establishing new and healthy routines in his new home."

Finally, the action steps listed by Ms. Boone to achieve this desired outcome include:

1. "find resources in new community to help establish new routines for daily living"

	2. "contact referral source (Men's health centre/Family Services)" 3. "contact private counsellors regarding possibility for couples counselling" 4. "go to FSENS (and Men's Health Centre) regarding previous referral" Ms. Boone testified as to what she meant by "Plan for activities of daily living" and "Practical assistance." The first includes ways Lionel Desmond could make healthy connections with his family and daughter on a regular basis. The second includes strategies to prevent Lionel Desmond from getting overwhelmed. It also includes a way of reducing barriers in "navigating the system". It would involve making phone calls and providing him with information in advance. Ms. Boone testified that strategically she would initially focus on only one (1) desired outcome. She testified as to why this was necessary and what she meant by "re-engagement with family." *"**A.** This was the start. But, again, because of the complexity of the needs of Lionel and because I noticed he became overwhelmed very easily, I didn't want to give him three to four things to work on because that would be way too much. That would overstimulate him. So I wanted to make sure that, Okay, the first thing we needed to do . . . and this was also if we triage, this was probably the most important thing that needed to happen from my understanding in that moment. And my experience with him in those two visits was to assist him with re-engagement with family and also establishing new and healthy routines in his new home. So that's step one.* ***Q.** And so what is, I guess, "re-engagement with family"?* ***A.** So, as I indicated, because he lived away for many years of their marriage and his daughter's life, being involved on a daily basis was something that he wasn't used to and they weren't used to. So, for example, if he just started disciplining his child, he needs to have some context to that and she needs to feel that there's a relationship there, too. Even though that's her father, he needed to feel like he was part of things and they needed more consistency with him living there. So it would be about helping him re-engage, reconnect with his wife, to be able to be part of the home again and not just a visitor."*	Transcript April 21, 2021 [pages 94 – 96] Transcript April 21, 2021 [pages 96 – 97]

December 9, 2016 #3	Lionel Desmond contacts Family Service of Eastern Nova Scotia (FSENS) by phone. He speaks with the administrator and advises he would like to enter into couples counselling with Shanna Desmond. He is given a January 16, 2017, intake appointment with Social Worker AnnDelynn MacDougall. Family Service of Eastern Nova Scotia (FSENS) is a registered not-for-profit organization. Historically, it provided services exclusive to Eastern Nova Scotia. However, it has now rapidly expanded services throughout the entire province. Family Service of Eastern Nova Scotia (FSENS) has a staff of approximately 55 individuals. Eighty-five percent (85%) of the staff are either social workers or registered counsellors. Family Service of Eastern Nova Scotia attempts to deliver "accessible care" at "no cost or minimal cost" to the individual. They offer 27 different programs based on three (3) modalities of intervention. These three (3) modalities are individual, couples, and family. Executive Director Nancy MacDonald testified: *"But we, as human beings, we have an immense need to be in relationships, and so we, our organization, it's important that we offer all three modalities of Counseling because if all we do is focus on the individual and we put all the weight of expectation on the individual, we're really not paying attention to the importance of the societal context and the fact that people experience mental health out here. They don't experience mental health within themselves only. And their experience in terms of on their journey to becoming well really needs to be contextualized to what's happening out in their environment".* According to Ms. MacDonald mental health services within Nova Scotia are classified on a 5-tier scale. Tier 5 is the most intense. Tier 1 includes community resources such as having access to a community library. In comparison, Tier 5 includes having access to a psychiatrist and in-patient mental health. Family Service of Eastern Nova Scotia (FSENS) is a Tier 3 service. Out of the many diverse programs offered by Family Service of Eastern Nova Scotia (FSENS) several are specifically designed for men. One (1) program currently in development is the "Strengthening Father's" program. This targets men who are at risk of being involved in family violence or intimate partner violence.	Exhibit P-000313 Transcript September 15, 2021 [pages 119 – 122] Transcript September 15, 2021 [page 9] Transcript September 15, 2021 [page 12] Transcript September 15, 2021 [page 26] Transcript September 15, 2021 [pages 28 – 31] Transcript September 15, 2021 [page 37]

	The focus is on prevention and early intervention. The program blends social supports with psychoeducational programming which includes anger management and respectful relationships counselling.	
	Family Service of Eastern Nova Scotia (FSENS) recognizes that there is a specific need for supports geared towards the unique needs of men. A more holistic approach to men's mental health is required. Out of this awareness Family Service of Eastern Nova Scotia (FSENS) opened the Men's Health Centre in 2008. It continues to be the only one of its kind in Nova Scotia. Ms. MacDonald testified: *"And so the Men's Health Centre tries to be grounded in the social determinants of health. So we try to make space for the fact that a loss of employment, the loss of a job, a loss of an income, a loss of a relationship, a new person to a town, culture, race, all of those social determinants of health are crucial to men or people who identify as being male."*	Transcript September 15, 2021 [page 57]
	The Men's Health Centre collaborates with various health care professionals. The centre has a mental health worker through mental health and addictions, social workers who offer family therapy, a family physician who attends one (1) day a week, and a navigator. The navigator assists with removing the social barriers of health and wellness. They assist in finding housing, employment, income assistance, and the basic necessities of living. Unfortunately, due to the restrictions on grant funding this valuable physician is not always available.	Transcript September 15, 2021 [pages 58 – 67]
	According to Ms. MacDonald, since the COVID-19 pandemic began in early 2020 there has been a 75% increase in males calling the provincial 2-1-1 navigation system seeking support. As a result, Family Service of Eastern Nova Scotia (FSENS) has collaborated with the Department of Community Services early intervention and the Status of Women to launch a 24-7 men's helpline within Nova Scotia. This helpline launched in September 2020. During the first year and without a robust awareness campaign they received over 1600 calls. Dr. Katreena Scott of the Centre for Research and Education on violence against woman and children at Western University is currently studying the effectiveness of this newly developed Men's Helpline within Nova Scotia.	Transcript September 15, 2021 [pages 100 – 104]

	Unfortunately, the Men's Helpline is currently not a core program within the province. Despite its early success, federal interest, and national attention, it has yet to be designated long-term funding.	
December 12, 2016	Lionel Desmond phones Clinical Care Manager Helen Boone. He advises that he now wishes to access couples counselling privately. He further states that Shanna Desmond would prefer not to access this service through Family Service of Eastern Nova Scotia (FSENS) because she has concerns that she may have interactions with some of her co-workers. As a result, Ms. Boone provides him with the names of two (2) private counsellors in his area. It is notable that domestic violence and marital breakdown between Lionel and Shanna Desmond are documented as far back as 2011. Despite this, Ms. Boone appears to be the first professional to ever assist in making concrete attempts at coordinating relationships counselling on behalf of Lionel and Shanna Desmond.	Exhibit P-000283 [page 2] Exhibit P-000288 [page 7] Transcript April 21, 2021 [pages 108 – 109]
December 13, 2016	Lionel Desmond visits the Guysborough Medical Clinic at 6:19 p.m. and is seen by Dr. Ali Khakpour, a family physician working in Guysborough at the time. Lionel Desmond was seeking treatment for a cut on the fourth finger of his right hand. Mr. Desmond told the doctor that he had sustained the injury from a broken dish while he was washing dishes. The cut was actively bleeding. Dr. Khakpour applied sutures to close the wound. On this occasion Dr. Khakpour did not observe Lionel Desmond exhibit any signs of psychological stress. The chart entry at 1855 indicates that Lionel Desmond tolerated the procedure well. According to the chart, at this time "Pt discharged amb $\bar{c}$ wife."	Exhibit P-000092 [pages 14 – 15]
December 14, 2016	Lionel Desmond attended at the Guysborough Medical Clinic at 11:43 a.m. to have his wound checked and to have his dressing changed.	Exhibit P-000092 [page 16]
December 14, 2016	Therapist Cathrine Chambers sends Lionel Desmond a text message reminding him of their scheduled appointment for December 15, 2016.	Exhibit P-000077

December 15, 2016	Lionel Desmond attends his second session with Therapist Cathrine Chambers. Although this is only the second time they meet in person, it will be the last. In total, over both sessions, Ms. Chambers was only ever able to spend approximately two (2) hours with Lionel Desmond. Ms. Chambers' initial impressions of Lionel Desmond are noted in her "**INDIVIDUAL PSYCHOTHERAPY ASSESSMENT FORM**": *"His affect was flat and his demeanour was meek and child-like. He was very polite and soft-spoken. His speech was often confusing, fragmented, and disorganized. It appeared to be difficult for Mr. Desmond to think and express himself clearly or in a linear fashion."* Ms. Chambers testified that during the two (2) sessions Mr. Desmond was difficult to draw information from. Other highlights from Ms. Chambers Individual Psychotherapy Assessment Form include: 1. *"Mr. Desmond reports that he and his wife frequently argue, particularly when Mr. Desmond's PTSD symptoms are more intense."* 2. *"Mr. Desmond has few friends in Nova Scotia but does keep in touch with one of his cousins whom he is close with. He reports feeling isolated, particularly when his relationship with his wife is strained."* 3. *"Mr. Desmond reported that his experience of inpatient treatment was not helpful. He reported that there were some good counsellors there but that the environment was too loud and overwhelming for him."* 4. *"It is unclear whether or not Mr. Desmond completed the inpatient rehabilitation program or if he was discharged early. His speech and narration of events is confused and disorganized."* 5. *"Mr. Desmond discussed the impact of the concussions, including frequent episodes of confusion and disorganized thinking, an inability to read music, not feeling like himself, abrupt changes in mood, increased compulsions around cleaning, and short-term memory impairments."*	Exhibit P-000076 [pages 4 – 5] Exhibit P-000076 [pages 1 – 3]

	6. *"Mr. Desmond wasn't sure of the names of the medications he was taking. Follow up with M. Doucette for further information."* 7. *"Mr. Desmond shared that he wants to have a happy and healthy home life and a healthy relationship with his wife. He would also like to be able to sleep better and find ways of dealing with intrusive memories and flashbacks."* 8. *"With regard to his relationship with his wife, Mr. Desmond reports that his PTSD symptoms impact his relationship and his ability to be the loving husband and father he wants to be."* 9. *"Mr. Desmond reports that alcohol and drugs have not been a primary coping mechanism. He reports that he rarely drinks but may do so on special occasions."* 10. *"He reported that he was trained to only sleep 3 hours at a time and had to constantly be ready to fight. Mr. Desmond reported that after he came back from Afghanistan he transferred to the military band, which was often very frustrating and humiliating for him as he couldn't read the music or figure out how to play his instrument. Mr. Desmond also suffered several concussions, which he reports have significantly impacted his daily functioning."* Ms. Chambers testified that as part of the six (6) sessions, which would have made up the "assessment phase," her plan was to do a risk assessment. She stated: a. *"I'm looking to do, also, a risk assessment, what's happening in terms of suicidal risk, homicidal risk, self-harm, other possible risks like substance abuse, eating disorders. This would be over the course of the full assessment. I'd be looking at those kinds of things."* b. *"It's exploratory, yeah. So I'm asking some probing questions, you know, what brings you here, what are you hoping for, what's been going on, how are you suffering, how are you coping, you know, if this was helpful what would be different for you at the end of this? You know, I'm kind of looking to see what their goals might be for the therapy."*	Transcript February 12, 2020 [page 174]

	During her short time with Lionel Desmond, Ms. Chambers made efforts to assess Lionel Desmond's suicide risk and his history of violence/homicidal ideation. However, she testified that, despite being familiar with various suicidal risk intervention tools, she did not use them. *"**Q.** Apart from asking the question in the way that you do, do you use, in your practice, any suicide risk assessment tools?* ***A.** No. It's informally woven into the context of the conversation. I don't use any formal assessment tools."*	Transcript February 12, 2020 [page 221]
	Ms. Chambers documents the following with respect to Lionel Desmond's suicide risk and his history of violence/homicidal ideation. *"**Suicidal Risk**: Mr. Desmond reports frequent suicidal ideation, mostly centering on the thought, "I wish I would have just gotten blown up in Afghanistan." These thoughts are present when Mr. Desmond is triggered and when his PTSD symptoms are worse. Mr. Desmond reported that he doesn't have a specific plan to end his life and has no intent to act on these thoughts. When asked how he would know if he needed to go to hospital, Mr. Desmond replied that he would go to hospital and check himself in if he felt overwhelmed and unable to cope.* ***History of Violence/Homicidal Ideation:** Mr. Desmond reports that he argues with his wife frequently, particularly when his PTSD symptoms are active and when he has been triggered. Mr. Desmond shared that he usually takes a drive or a walk to cool off when they get into an argument. Mr. Desmond did not report any incidents of physical violence in the home or a history of violence in his relationship with his wife."*	Exhibit P-000076 [page 3]
	It is apparent that Cathrine Chambers is missing essential information as it relates to Lionel Desmond's complex mental health profile. This significantly limits her ability to properly conduct a timely and thorough assessment. Within her Individual Psychotherapy Assessment Form, she notes: *"… frequent oscillations between hyper- and hypo-arousal of the autonomic nervous system; sleep disturbance; loss of interest in activities of daily living; loss of a sense of self and purpose in life; difficulty in intimate relationships; feelings of hopelessness about the future."*	Exhibit P-000076 [page 4]

	Furthermore, the lack of sharing also negatively impacts her ability to fully appreciate and plan for Lionel Desmond's risk for suicide and violence/homicide. Ms. Chambers never gets close to beginning the "community-based psychotherapy" which was the very purpose of the Veterans Affairs Canada (VAC) referral. Several examples of the lack of information sharing includes: 1. Ms. Chambers knows nothing of Lionel Desmond's struggles and treatments while a member of the Canadian Armed Forces (CAF). 2. Ms. Chambers knows nothing of his assessments and treatments while at the New Brunswick OSI Clinic between May 7, 2015, and December 22, 2016. She only knows that he had been involved with that clinic. 3. Ms. Chambers knows little of the assessments and treatments which took place at the Ste. Anne's program other than Lionel Desmond's self-report that it "was not helpful." As well, she does not know his reason for leaving early and when he does speak of it his narration of events are confused and disorganized. 4. She is unaware of Lionel Desmond's long-documented history of suicidal and homicidal ideation. He never reveals to her and she does not have access to the records which document them occurring on a daily basis. 5. She is unaware what medications Lionel Desmond has been prescribed and his history of noncompliance. 6. She knows nothing of the past RCMP occurrences. 7. She is left with Lionel Desmond's self-reported minimization of the extent of his alcohol and cannabis abuse. 8. She knows very little of the long-standing domestic violence within the relationship with Shanna Desmond. Essentially, she is left to formulate overly simplistic impressions such as they "frequently argue," "his relationship with his wife is strained." *"Mr. Desmond didn't share anything with me about a possible separation or divorce. That was never brought up. He, you know, did*	Transcript

	talk about wanting to be the best father and the best husband that he could be and that sometimes he did argue with his wife. I asked him and probed a little bit more about that, but my sense was that they were working on trying to have a healthy relationship." 9. She is unaware that Lionel Desmond had recently been seen and assessed by Psychiatrist Dr. Ian Slayter on two (2) occasions. a. October 24, 2016, St. Martha's Hospital Emergency Room b. December 2, 2016, Dr. Slayter's office 10. She is unaware that Lionel Desmond recently attended the Guysborough Memorial Hospital Emergency Department on November 2, 2016, with complaints of ongoing PTSD symptoms. Ms. Chambers testified that she would have liked to have had more information surrounding Lionel Desmond's diagnosis and his treatment history. She also indicated that had she known of the existence of other healthcare professionals she would have collaborated and shared information with them. *a. "Yes, I would have liked to have known what diagnosis he did receive and who made those diagnoses, how long he had had those diagnoses as well as what treatments had already been offered. That would help me to determine what treatments had been helpful and what treatments had not been helpful."* *b. "Well, the nature of the collaboration would be to ensure that we were all working with the same information, also to ensure that we were all assessing for risk and that we were all conveying the same messages to Mr. Desmond in terms of supports, what was necessary, and how we could be of service to him. So it would be about collaborating and offering sort of a wraparound with his care so that we weren't operating in silos. That would have been the point of that consultation."* Ms. Chambers testified that in her short time with Lionel Desmond she became aware that Helen Boone had also been recently retained by Veterans Affairs Canada (VAC). Although Ms. Chambers had never collaborated with a clinical care manager before she believed it would have been beneficial as things progressed.	February 12, 2020 [page 190] Transcript February 12, 2020 [page 203] Transcript February 13, 2020 [page 39]

	However, Ms. Chambers and Ms. Boone never did collaborate on Lionel Desmond's care. Ms. Chambers testified: a. *"Yes, my understanding was that Marie Paule Doucet* [*sic*] *would be communicating with Helen Boone and that Helen would be reaching out to me so if I needed to reach her, I could have gotten the information from the case manager."* b. *"**A.** Yes, it would be I would have to get a consent from Mr. Desmond to communicate with the clinical case manager and sign a release.* ***Q.** Okay. So I appreciate this is what you understand and it just strikes me that you're engaged under the Veterans Affairs' system, you're working alongside of the clinical care manager with the case manager to support him, and it seems to me that this extra level of getting consent to communicate with those people with the team is a barrier.* ***A**. I would characterize it as a barrier."*	Transcript February 13, 2020 [pages 76 – 78]
	The lack of critical information sharing limits and delays Ms. Chambers' ability to fully engage Lionel Desmond in safety planning and identifying formal and informal supports. With respect to this Ms. Chambers testified: *"It was quite a lot of complexity in Corporal Desmond's case. He had a lot of additional challenges and as well, the way that he shared information, because of the disorganization and some of the confusion, it took extra time to gather that information beyond the normal timeline."*	Transcript February 13, 2020 [page 79]
	Finally, Ms. Chambers testified that had she known the full extent of Lionel Desmond's complex psychological profile and his clinical instability she would not have considered herself as a suitable professional in the circumstances. *"Certainly in light of the information that you've shared from this report, I don't believe Mr. Desmond would have been a candidate for community-based psychotherapy but would have required further inpatient care."*	Transcript February 13, 2020 [page 141]
December 19, 2016		Exhibit P-000092

	Lionel Desmond attends the Guysborough Medical Clinic at 10:37 a.m. to have his dressing changed. At 11:15 a.m. he stated that he wished to make an office appointment for a prescription refill. An appointment was made for 10:15 a.m. the next day.	[pages 18 – 19]
December 20, 2016	On this day, Lionel Desmond attends at the Guysborough Medical Clinic and again meets with Dr. Khakpour. The chart entry from this day contains the following: *"1-Needs a refill for Zolpidem.* *Will see Dr. Slayter tomorrow . He says that still he is depressed with the PTSD after serving army abroad in war zone. He is not suicidal or homicidal"* Dr. Khakpour refilled his prescription for Zolpidem which is a hypnotic to assist with sleep. Dr. Khakpour was able to access the previous entry made by Dr. Harnish. He was able to see that he had been suffering from PTSD and that he had been in Quebec and in New Brunswick. He also was able to see that Mr. Desmond "had kind of suspicious idea or paranoid." Lionel Desmond described for Dr. Khakpour that he was not feeling well and that he continued to suffer the symptoms of his PTSD. He described his memories of having been in a war zone. Dr. Khakpour did not believe that Lionel Desmond was actively suicidal at that time. Dr. Khakpour was comforted by the fact that Lionel Desmond had an appointment to see Dr. Slayter the next day and that he had attended at the clinic on four (4) occasions.	Exhibit P-000092 [page 20] Transcript March 10, 2021 [page 66]
December 21, 2016	Lionel Desmond does not attend for his follow-up appointment with Dr. Slayter.	
December 22, 2016	**<u>Continuity of Care Gap #10: Lack of Community Treatment Plan between Ste. Anne's Discharge (August 16, 2016) and New Brunswick OSI File Closure (December 22, 2016): Approximately 4 months</u>** Dr. Murgatroyd writes a letter to Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette. Mr. Desmond's New Brunswick OSI file is formally closed. Dr. Murgatroyd's closing letter indicates:	Exhibit P-000244 [pages 3 – 6]

		"… *Mr. Desmond is now permanently living in Nova Scotia. And it is my understanding that he is connected with a local mental health team. Therefore, his file at the OSI Clinic will be closed at this time*." Other than a single phone call on August 24, 2016, Lionel Desmond does not appear to have had any support from the New Brunswick OSI Clinic in the four (4) months since his August 15, 2016, discharge from Ste. Anne's. This lack of contact is notable. Lionel Desmond in many respects has still yet to be stabilized when he left Ste. Anne's. As well, his anger, resentment, and mistrust relating to Shanna Desmond remain at the forefront. Most recommendations set out in the August 17, 2016, Ste. Anne's Interdisciplinary Discharge Summary report have yet to be implemented. Mr. Desmond remains in the community with what appears to be few local supports.	
Dec. 27,	**2016**	A detailed four (4) page Psychological Evaluation Report is prepared by Psychologist/Coordinator Dr. Isabelle Gagnon. Again, there is a considerable delay in preparing this report and sharing vital information. Dr. Isabelle Gagnon is Lionel Desmond's Ste. Anne's case coordinator. This report is not completed until approximately four (4) months after his August 15, 2016, discharge and only six (6) days before the tragic events of January 3, 2017. As well, a second document titled "**CLOSING NOTE**" is also prepared. This report outlined the summary of interventions and recommendations for continuity of care. Just like the detailed Psychological Evaluation Report it is not prepared until six (6) days before the tragic events of January 3, 2017. Neither of these two (2) documents or any of the 400 page Ste. Anne's medical file are ever shared with the New Brunswick OSI Clinic, Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette, or any other known healthcare provider. As outlined previously, the only document to be shared/requested from Ste. Anne's was the late disclosed seven (7) page Interdisciplinary Discharge Summary report. Given that these critical reports are never shared nor completed until six (6) days before the tragic events, Mr. Desmond is never given a full opportunity to participate in a meaningful and structured continuity of community care plan. How such a treatment structure could even be organized without such vital	Exhibit P-000254 [pages 301 – 306]

		information from the Ste. Anne's case coordinator appears to be a mystery. Timely sharing of critical information was lacking.	
December 27, 2016		Dr. Isabelle Gagnon's four (4) page Psychological Evaluation Report contains the results of various psychometric tests such as the Outcome Questionnaire-45.2, Post traumatic Checklist-5, and Millon Clinical Multiaxial Inventory-III. Some of the highlights from the Psychological Evaluation Report include: 1) *"Mr Desmond frequently arrives late or not at all to scheduled meetings, requiring a professionnal* [sic] *to find him and remind him of these meetings. The client displays pressured as well as tangential speech patterns. He alternates rapidely* [sic] *between different emotional states during the interviews, laughing loudly one moment and displaying prononced* [sic] *anger the next. Mr. Desmond seems to experience anger particularly when discussing past events which caused him to feel slighted or neglected, and exhibits signs of anger such as a clenched jaw, raised voice, finger pointing, unblinking eye contact and bared teeth. When we observe the client cycle rapidely* [sic] *between extreem* [sic] *good mood and anger, exhausted emotional numbing is often present at the end of the session."* 2) *"The client initially identifies his marital relationship as the main source of distress, but upon further exploration, reports the following difficulties. Mr. Desmond indicates having sleeping difficulties, partly due to recurring nightmares of finding his wife cheating on him and of attacking her and her lover. When questionned* [sic] *on symptoms related to trauma events, the client states that he cannot think of the past and refuses to elaborate."* 3) *"The client mentions that yelling in the context of conflicts seems to trigger intrusive images from his deployment in Afghanistan. In response to activation of traumatic memories or to a physiological arousal, the client would now choose to leave the situation and to isolate himself. In the past, Mr. Desmond would have become aggressive, both verbally and physically."*	Exhibit P-000254 [pages 301 – 304]

	4) *"Finally, as for hypervigilance, Mr. Desmond displays interpersonnal* [*sic*] *distrust, with some interpretations of events which verge on persecutory dellusions* [*sic*]*."* 5) *"Mr. Desmond seems to have difficulties assimilating information, often seeming to misunderstand questions or assigned exercises. Planning futur* [*sic*] *events also seems to be difficult …"* 6) *"Action interruption also appears to be a challenge for the client, as he seems to repeat the same stories throughout our meeting and sometimes even in the course of one session."* 7) *"In fact, Mr Desmond often seems to make leaps when interpreting other's actions, often coming to conclusions which are hard to follow. A significant portion of these interpretations seem to be of a persecutory nature, and the client exhibits marked cognitive rigidity, maintaining these interpretations even when emphatic questionning* [*sic*] *reveals gaps in logic. For instance, upon hearing two professionnals* [*sic*] *laughing together following a clinical meeting, Mr. Desmond states that he is aware of the fact that the professionnals* [*sic*] *laugh about him during meetings."* 8) *"Mr. Desmond does not report any suicidal or homicidal ideation. In response to the client stating that if people disrespect him, they will see the beast aspect of him, Mr. Desmond states he would never hurt anybody."* 9) *"To account for the client's clinical presentation, we posit a complexe* [*sic*] *interaction between a traumatic portrait, experiential avoidance and personnality* [*sic*] *traits, and we underline the potential input from cognitive dysfonctions* [*sic*]*. We can only provide an approximate picture of the client's traumatic profile due to the client's reticence to discuss past events. However, we consider that this very reticence speaks to the proeminence* [*sic*] *of avoidance in the client's clinical portrait."* 10) *"However, when distressing subjects are brought up, such as marital conflicts, the client displays more pronounced tangential speech patterns and provides more evasive*	

	answers. We believe this could partly be due to the presence of limited abilities to regulate distressing emotional states." 11) *"Indeed, Mr. Desmond seems to display a profile in which borderline personnality* [*sic*] *traits seems proeminent* [*sic*]. *In our sessions, and as reported by professionnals* [*sic*] *on the unit, Mr. Desmond displays rapidely* [*sic*] *fluctuating emotional states, where anger is often represented and expressed in an inappropriate manner."* 12) *"We also observe an underdevelopped* [*sic*] *sense of identity, particularly without the identitary* [*sic*] *basis provided by the Canadian Armed Forces."* 13) *"Some limited observations also lead us to suggest the need for further exploration of dependant personnality [sic] traits, as Mr. Desmond seems to expect others to assume responsability* [*sic*] *for various areas of decisions and to react with resentment when these expectations are not met."* 14) *"Given the interactions of these different factors and because of the potential input of brain trauma, we hesitate to provide a decisive diagnosis."* 15) *"<u>Provisional diagnostic impression:</u>* 1. *Post-traumatic Stress Disorder;* 2. *Borderline personnality* [*sic*] *traits."*	
	Highlights from the December 27, 2016, Closing Note include: 1) *"The client initially presented with complaints regarding his family interactions and his difficulties regulating and expressing anger in a constructive manner. Several incidents were recounted in which Mr. Desmond seemed to exclusively focus his time and energy on an external stressor, to the detriment of his continued well-being."* 2) *"… Mr. Desmond was able to recognise a pattern of damaging interpersonal behaviors, as the end of*	Exhibit P-000254 [pages 305 – 306]

	treatment neared, the client seemed to express growing doubts about the intentions of the treatment team which led to increased distrust and isolation." 3) *"Firstly, due to observed and reflected difficulties in the area of behavior inhibition and memory as well as reported incidents in which head injuries might have been present, we recommend a detailed neuropsychological evaluation. Continued work in developing skills in emotional regulation would also seem beneficial in helping the client manage life stressors."*	
December 31, 2016/January 1, 2017	Upon returning from a New Year's Eve party, Lionel Desmond is operating the couple's truck and has a minor accident where the truck slides into the ditch on an icy road. This event causes Lionel Desmond considerable stress. Thelma Borden described the incident as it was related to her by Shanna before her death: *"20 (e) Shanna told me about an incident on New Year's Eve 2016 that she and Lionel had been at my sister Liz's camp and Shanna, Lionel, Aaliyah and Brenda were driving in Shanna's truck with Lionel behind the wheel going back to my home when because of the icy roads, the truck slid off into a ditch. Lionel got very upset and blamed the incident on Shanna.* *(f) Shanna told me Lionel wouldn't let the truck incident go, he had trouble letting things go since he came back from Afghanistan, he went on about the incident for days.* *(g) Shanna told me she told Lionel he had to leave – Lionel said "I am not leaving, no place, you're not taking my daughter, you can call the cops, I'm not leaving, I'll have something for them (the cops) when they come." Lionel was up in her face and she had to leave the home with Aaliyah and go for a drive. After that, Lionel texted Shanna accusing her of being with somebody.* *(h) Shanna would tell Lionel he had to get help.* *(i) Lionel would go around the house banging things.* . . .	Exhibit P-000170

	(m) Shanna told me the night before she died that she told Lionel "Lionel, I can't do this no more". *(n) Shanna told me she wanted a divorce. She said she couldn't deal with it any more."*	
January 1, 2017	Lionel Desmond attends the Emergency Department at St. Martha's Regional Hospital. He is first seen by triage nurse, Amy Collins. Her triage assessment states: *"PT DEALING WITH PTSD SINCE <2011. PT HAD A BAD DAY TODAY. ARGUED WITH PARTNER. WALKED ALOT TO TRY TO CALM DOWN. FEELS IS NOT COPING WELL AND IS LOOKING FOR ADMISSION. CALM AND SPEAKING QUIETLY."*	Exhibit P-000067 [page 33]
January 1, 2017	Lionel Desmond attends at the Emergency Department of St. Martha's Regional Hospital. He is seen by Dr. Justin Clark, the on-call physician in the Emergency Department. Dr. Clark's entry on the chart was recorded as follows: *"Time seen - 19:09. 33-year old. Ex-military. History of PTSD. Diagnosed in 2011. Followed by Dr. Slayter and Veterans Affairs. Issues at home. Has a wife and a nine-year old child. Outburst tonight. Breaking furniture. No harm to family per patient. Wife told him, 'Don't come back until tomorrow.'"* Dr. Clark observed Lionel Desmond's demeanour to be calm, polite and cooperative. Dr. Clark learned that Lionel Desmond was a former soldier who suffered from PTSD. Dr. Clark felt that Lionel Desmond should be seen by the on-call psychiatrist, who on this day was Dr. Faisal Rahman. Dr. Rahman is now the Chief of Psychiatry for the Eastern Zone (NS). Prior to that, he was the Chief of Psychiatry and Clinical Director at St. Martha's Regional Hospital. Dr. Rahman was contacted by Dr. Clark at approximately 7:30 p.m. and attended at the Emergency Department and saw Lionel Desmond. Initially, Dr. Rahman knew that Lionel Desmond was a veteran and that there had been some conflict in his family life. He had an opportunity to look quickly at Lionel Desmond's outpatient	Exhibit P-000067 [page 33] Transcript February 3, 2020 [pages 62 - 63]

	chart and learned that he had been seen by Dr. Slayter on December 2, 2016. After reviewing the outpatient chart, Dr. Rahman met Lionel Desmond at approximately 7:40 or 7:45 p.m. in the family room of the Emergency Department. Lionel Desmond was alone on this occasion. He was observed by Dr. Rahman to be calm and composed at this time. Dr. Rahman spoke to Lionel Desmond at this time for approximately 30-40 minutes. In his Physician Progress Notes, Dr. Rahman recorded the following: *"Pt. is a 33 Yo retired Veteran from Army, having served in Afghanistan for 7-months in 2007, and suffering from PTSD and being f/u by Dr. I. Slayter and Veteran's Affairs therapists & social work. He indicates h/o TBI. Lives with wife of 10 yr and 10 yr old daughter. Has h/o Anger Management issues and longstanding inter-personal conflicts with wife. He apparently had a verbal altercation with his wife who apparently asked him to leave the premises until he feels more under control. He has been intermittently been* [*sic*] *advised by his wife to spend night elsewhere & return to home the next day or so. He has been living* $\bar{c}$ *his wife who is an employee at Saint Martha's Hospital and their 10 Yo daughter. The wife had called police on him on few occasions in the past but he left the house before police arrived. He states that argument between him & his wife started last night when their vehicle went into a* [scribble] *ditch. Both continued to escalate until he punched/hit a table at which point she threatened him about calling RCMP &* [scribble] *he left the home voluntarily. He does complain of symptoms suggestive of PTSD, continues to experience flashbacks, nightmares, sleep is disturbed, frustration tolerance remains low & he feels that he does not get any affection from his wife who is dismissive of him. He denies abusing her physically. There is no current legal hx. He denies drinking alcohol. Wishes to stay in the hospital overnight to reflect & regroup. He has appts.* $\bar{c}$ *his therapist (through VA) tomorrow. He denies any suicidal or homicidal ideation. Thought process is coherent, logical & goal directed."* Lionel Desmond reported to Dr. Rahman that the conflict with his wife Shanna was longstanding and that it involved financial issues relating to his financial support of her education.	Transcript February 4, 2020 [page 64] Exhibit P-000067 [pages 38 – 39] Transcript February 4, 2020

	Lionel Desmond told Dr. Rahman that Shanna has contacted the police in the past and that this causes him frustration. Dr. Rahman asked about guns and he reported that the police had taken his guns on a previous occasion. He described for Dr. Rahman a prior suicidal "gesture" in New Brunswick which he said he did to seek help.	[pages 74 – 75] Transcript February 4, 2020 [pages 76 – 77] [pages 89 – 90]
	Lionel Desmond described some details of his service in Afghanistan. He talked about his prior psychiatric history including being at Ste. Anne's Hospital in Montreal, his prior use of marijuana, and his history of traumatic brain injuries.	
	Dr. Rahman was of the opinion that Lionel Desmond did not meet the criteria for admission under the *Involuntary Psychiatric Treatment Act.* Dr. Rahman assessed his suicide risk as low/mild.	Transcript February 4, 2020 [pages 94 – 95]
	Dr. Rahman understood that Lionel Desmond had nowhere else to go that night as he had been asked to leave the home by Shanna. Dr. Rahman felt that Lionel Desmond could stay at St. Martha's as a "social admission" as he had nowhere else to go. Normally a patient would stay in the inpatient psychiatry unit, however, as Shanna worked at the hospital, Lionel Desmond asked not to go to that unit. He was allowed to stay overnight in the observation area of the Emergency Department.	Transcript February 4, 2020 [pages 99 – 100]
	He was to be monitored by staff every hour. Dr. Rahman prescribed medications on an as-needed basis to assist Lionel Desmond with his sleep. Dr. Rahman left the Emergency Department at approximately 9:30 p.m. It was anticipated that Lionel Desmond would be leaving the Emergency Department the next day.	
	Through the night, Lionel Desmond was observed by the nursing staff. Their entries on the chart are as follows: err. LG *"1910 Pt. assessed by Dr. Clarke. 2000 Pt. assessed by Dr. ~~Romand~~ Rahman. 2015 Plan to keep pt overnight in obs. Pt. transferred to obs bed 2. Orders received + carried out. Pt settled to bed – pt. calm + cooperative. 2110 Pt up to bathroom ambulatory – no voiced concerns ~~@ present. 0045 Pt. stating unable to sleep – medi~~cated as per PRN orders. 0150 Pt stating still unable to fall asleep – asking for his usual sleeping pill that he didn't take into hospital c̄ him.– medication unavailable in hospital @ present. Warm blanket provided, will cont. to monitor. 0635 Pt. states had poor sleep. Checked on hourly. No voiced concerns @ present. Will continue to monitor.* ———— LG	Exhibit P-000067 [page 34]

	0710 - Report received from Leanne RN. 0830 Vitals 36.7, 78, 18, 109/62, Ⓛsemi, 95% RA. Pt stated, restless T/O night. flat affect. Ø pain/concerns. Awaiting discharge."	
January 2, 2017	Dr. Rahman recalls seeing Lionel Desmond for approximately five (5) minutes. Dr. Rahman offered Mr. Desmond another night, however, he wished to leave hospital. Dr. Rahman discharged Mr. Desmond. Dr. Rahman reiterated that Mr. Desmond should make the follow-up appointment with Dr. Slayter. Dr. Rahman recorded the following on Lionel Desmond's chart: *"Pt. feeling better, requesting discharge, will discharge to home, does not meet criteria for involuntary hospitalization: Slept well; Ø SI, Ø HI."* Dr. Rahman's entry that Mr. Desmond had slept well was based on Mr. Desmond's comments to that effect (albeit contrary to the observations of the nurse on duty). Lionel Desmond leaves St. Martha's Hospital shortly after 11:00 a.m. according to the nurse on duty.	Transcript February 4, 2020 [pages 130 and 135] Exhibit P-000067 [page 39]
January 2, 2017 #1	Lionel Desmond calls Clinical Care Manager Helen Boone. Ms. Boone testified that during this call Lionel Desmond "sounded distressed" and was calling in a moment of "crisis." Ms. Boone documented the following: *"January 2, 2017 - client called CCM. He disclosed holidays were tough as he and his wife were not getting along. He explored his relationship concerns. CCM encouraged client to contact his therapist (which client agreed). We explored ways client needs to work on individual issues before couples counselling could be effective. Client agreed to utilize previous referral I gave him to explore options for issues surrounding housing and (if wife wants him to move out) as well as other community resources to minimize client"s* [sic] *feelings of isolation. Agreement made for client to contact FSENS when they re-open Tuesday as well as contact his counsellor for individual support."* Lionel Desmond begins the call by telling Ms. Boone about the argument he had with Shanna Desmond on New Year's Eve. The argument revolved around him putting the truck off the road. He	Transcript April 21, 2021 [pages 110 and 124] Exhibit P-000283 [page 2] Exhibit P-000288 [pages 7 – 8]

	advised that as a result of the rising tensions and argument he left the family home and attended St. Martha's Hospital in Antigonish. In relation to the short overnight hospital stay Ms. Boone testified, "His words was, I went to the hospital, they said I didn't need to be there and it didn't help." Ms. Boone further testified to other concerns as relayed by Mr. Desmond during this call. *a. "He said that the holidays were really rough, that things didn't go very well with him and his wife. He felt that his wife wasn't engaging in trying to work on their marriage. He was stating that he was frustrated. He said he was trying to not be drinking, but she was drinking and that he felt that if she was really supporting him in his sobriety that she wouldn't be consuming alcohol."* *b. "**A.** He felt that he was trying very hard to get the help for their marriage but she had checked out.* ***Q.** And "checked out" as in?* ***A.** That she wasn't really interested in repairing their marriage."* Equally significant, Lionel Desmond reports to Ms. Boone that Shanna Desmond had told him that he may not be able to see his daughter Aaliyah. *"And he told me that she had said that if he doesn't have a good place to live, he won't be able to have their daughter. And he's like, Helen, I need to do what I need to do. I still have to be a good father. So he talked about the fact that he needed some more help. So we . . . I again redirected him back to his counsellor. And then I revisited the whole notion about Family Services, about how . . . there was two parts to the referral. One was about couple's counselling, which, you know, It did not work for your wife, but getting support from the Men's Health Centre could be another area where you could feel support and encouragement and so he agreed that he was going to call them the following day when they reopened. He agreed to that."*	Transcript April 21, 2021 [page 126] Transcript April 21, 2021 [page 111] Transcript April 21, 2021 [page 112] Transcript April 21, 2021 [page 115]

	Despite his reported level of distress and the very recent rising tensions in his relationship with Shanna Desmond, Ms. Boone testified that he denied having any suicidal or homicidal ideation during this phone call. *"I'm going to try to provide the support. So reminding him that, You know what . . . I said, Your counsellor . . . like today is a holiday . . . because I believe in that year, the 2nd was a holiday, I think. And his counsellor would be back in the office tomorrow. So we reviewed, Are you okay to wait until then? Are you safe? And I go through the whole litany about safety concerns and risk management about whether he's safe, whether he's thinking about harming himself or harming anybody else. He denies all of those feelings. He denies any suicidal ideation. He denies any homicidal ideation."* The phone call concludes with a "plan of action." Lionel Desmond agrees that he will contact his Therapist Cathrine Chambers. He also commits to contacting Family Service of Eastern Nova Scotia (FSENS) when they open on January 3, 2017. Finally, he agrees that he would again call Helen Boone if things change or that he feels the need for someone to talk to. *"He sounded sad. He was upset, clearly, about his marriage ending. He still wanted to work on his marriage. He still sounded future focused and hope focused because he still wanted to look at repairing . . . making sure that he was doing well enough to be a good father to his child because he and I, in that conversation . . . I didn't get a chance to review all my notes, but just from my recollection we also had discussions about the fact that how important it was for him to be healthy emotionally in order to be a good father, in order to be a good husband. So that, you know, even if right now his wife had concerns that perhaps he wasn't healthy enough to be in a relationship that you have to work on getting healthy yourself."*	Transcript April 21, 2021 [page 114] Transcript April 21, 2021 [page 117]
January 2, 2017 #2	After Lionel Desmond misses his December 19, 2016, appointment with Therapist Cathrine Chambers she leaves him a voice message confirming that it has been rescheduled for January 5, 2017. At 6:53 p.m. on this date, Lionel Desmond leaves a return voice message for	Exhibit P-000077

	Ms. Chambers. He indicates he missed her call and is requesting that she contact him tomorrow (January 3, 2017).	
January 2, 2017	Lionel Desmond speaks with his uncle, Kenny Greencorn, by telephone at 1:20 p.m. for approximately two (2) minutes. Lionel Desmond told Mr. Greencorn that he had gotten out of hospital that morning. Mr. Greencorn invited Mr. Desmond to their residence. Later that afternoon, Lionel Desmond arrived at Mr. Greencorn's residence and the two (2) men talked. Lionel Desmond was at Mr. Greencorn's residence for one (1) to two (2) hours. Lionel Desmond then left the Greencorn home. At approximately 8:30 p.m., Lionel Desmond calls Mr. Greencorn about a snowblower which he needed to have serviced. Mr. Greencorn went to Mr. Desmond's home. Mr. Desmond was alone. Mr. Greencorn said this to police in his January 5 statement:	Transcript March 25, 2021 [pages 35 – 38]
	"So anyway, he went down the road. And that evening he called me around, say, half past 8, quarter to 9. Come down and get his snowblower. Went down, get his snowblower. I said . . . he went in the shower to have a shower and he come out, they were gone. He said they took off on him and left him. So he said he was getting out of there and so …" Lionel Desmond returned to Mr. Greencorn's house to assist in unloading the snowblower. Lionel Desmond stayed at the Greencorn home that night. That day he told Mr. Greencorn that he was going to see a counsellor the next day. Mr. Greencorn was unaware whether he had done that. He also recalled Mr. Desmond speaking about a divorce. Chantel Desmond is at bingo with her mother Brenda Desmond and has a conversation about the events of New Year's Eve. In her statement Chantel Desmond states the following:	Exhibit P-000164 [page 3]
	"I guess that's where it all started from. My mom said he just got mad and snapped and left. But he said Shanna kicked him out from what I'm told here. My mom still stayed. I told my mom last night at bingo, Mom, mind your business. Lionel's going to snap. I just have that feeling because we were close. He's like . . . she's like, I'm not there to worry about them. I'm there to protect Aaliyah. And she died protecting her basically."	Exhibit P-000165 [page 15]

	Thelma Borden recalls the following from the night before the incident: *"21 (g) The night before the incident, Shanna called me and put me on a three-way telephone call with Lionel and I remember Lionel apologizing to Shanna, asking her for help, accusing her of wanting to put him in the hospital for the rest of his life saying he wouldn't stay in the hospital, that they would find him in a body bag."*	Exhibit P-000170 [page 4]
January 3, 2017 12:47 p.m.	Lionel Desmond contacts Family Service of Eastern Nova Scotia (FSENS) for a second time. Phone records indicate that he leaves a voicemail message at 12:47 p.m. The records further indicate the call is returned by Family Service of Eastern Nova Scotia (FSENS) at 1:54 p.m. During this call which lasts for six (6) minutes and 57 seconds Lionel Desmond requests that the scheduled January 16, 2016, appointment be changed from couples counselling to individual therapy. The Family Service of Eastern Nova Scotia (FSENS) file record reads: *"Jan 3rd, 2017 - Call from Lionel stating that he will be coming for therapy himself, he would like to have his partner join him later if things work out. Lionel is still living at same address but states he is trying to get a place in Antigonish. MB"* Director Nancy MacDonald testified that staff did not note anything unusual or concerning about this conversation. There was nothing to suggest that Lionel Desmond was in crisis or in a form of duress during this call. If there was cause for concern, she testified they would have acted upon it in accordance with experience and training.	Exhibit P-000099-B [page 12] Exhibit P-000099-A [page 5] Exhibit P-000313 [page 2] Transcript September 15, 2021 [pages 143 - 146]
January 3, 2017	Lionel Desmond attends at St. Martha's Regional Hospital outpatient clinic for Adult Community Mental Health and Addictions Services at approximately 1:00 p.m. and books a follow-up appointment with Dr. Slayter. Medical Secretary Joan Hines makes the appointment for January 18, 2017, at 3:00 p.m. Lionel Desmond stated that he had been told by Dr. Rahman to book the appointment. He stated he missed the December 21, 2016, appointment due to weather. Lionel Desmond was described as calm.	Transcript February 12, 2020 [pages 84 – 86]

January 3, 2017 1:00 p.m.	Lionel Desmond had missed his December 19, 2016, appointment with Therapist Cathrine Chambers. This appointment was rescheduled for January 5, 2017. On January 2, 2017, Lionel Desmond leaves Cathrine Chambers a voicemail asking the date of his next appointment. Cathrine Chambers returns his call on January 3, 2017. She testified that the time of the January 3, 2017, call was "Early afternoon at maybe approximately 1 o'clock or so." She anticipated the conversation would be short and simply to confirm the next scheduled appointment. However, the call lasted for 26 minutes. Once the call began Lionel "immediately started to talk about the events of January 1st and 2nd." Ms. Chambers summarized the conversations in her notes:	Transcript February 13, 2020 [pages 5 – 14]
	"Mr. Desmond reported that he was in a car accident on the evening of December 31, 2016. He was driving home with his wife from a New Year's party. She had been drinking and he reported that she was "back-seat driving." Mr. Desmond reported that he followed her prompts to drive further to the right side of the road and the car went off the road. Mr. Desmond reported that he and his wife then got into an argument and his wife recommended that he go to hospital. Mr. Desmond reported that he did go to hospital and was discharged the next day. When asked if he received any medications at the hospital, Mr. Desmond responded that he only received his regular medication and was not given any PRN's. *Mr. Desmond reported that on January 1, 2017, his wife Shanna asked for a divorce. Mr. Desmond reported feeling anxious and stressed about this, and reported an increase in his PTSD symptoms as a result. Mr. Desmond reported that he decided to stay with his aunt until he could find his own apartment and that his wife and daughter were staying at the family home. Mr. Desmond agreed that he would return to hospital if he felt overwhelmed or unable to cope. A safety plan and contract to this effect was agreed upon verbally during a phone call on January 3, 2017. Follow-up phone call placed to Marie Doucette, VAC Caseworker, on January 3, 2017 to inform her of such.* *Next consultation scheduled for January 5, 2017. Mr. Desmond agreed that the focus for that meeting will be securing safe and affordable housing in Antigonish. Mr. Desmond also stated that he would go to the bank to open a new account the following day in*	Exhibit P-000076 [page 4]

	order to ensure he would have access to his pensions. Mr. Desmond stated that he felt Antigonish was too expensive and was thinking about moving back to New Brunswick. On the advice of Marie Doucette, VAC caseworker, Mr. Desmond and I agreed to reach out to Helen Boone, VAC Clinical Case Manager, during our next scheduled meeting about possible resources to support him during this transition." Ms. Chambers testified that she believed that Lionel Desmond "was in crisis" during their call on January 3, 2017. Therefore, she had him verbally agree that if he felt overwhelmed or unable to cope he would return to the hospital. She indicated she was on vacation and therefore did not meet with him in person. In describing his demeanor during this call Ms. Chambers testified: *"He did not sound particularly agitated, that's something that I was listening for. He was calm. He said that he didn't have any plans to hurt himself or anyone else.* *He shifted to speaking very specifically about his plans for the future. He noted that he was going to have to look for safe and affordable housing. He also talked about wanting to make sure that he had access to his pensions and talked a lot about banking and housing, in particular, so he was oriented to the future.* *He was speaking in very practical terms about what his next steps would be. And I asked him how he would know if he needed to go back to the hospital. And he said . . . first he didn't answer, and I said, Well, what about those thoughts that you told me about, wanting to be blown up? And he said, Yes, if I have those thoughts or they get worse. And, I said, or if you have thoughts of hurting yourself or someone else that would be a reason to go back? And he said, Yes."*	Transcript February 13, 2020 [pages 14 – 15]
	Essentially, Ms. Chambers testified that during this call Lionel Desmond presented consistent with her past interactions with him. In her report she notes Mr. Desmond's affect: "*… was flat and his demeanour was meek and child-like. He was very polite and soft-spoken. His speech was often confusing, fragmented, and disorganized. It appeared to be difficult for Mr. Desmond to think and express himself clearly or in a linear fashion."*	Exhibit P-000076 [pages 4 – 5]

Jan. 3,	**2017**	At some point during the afternoon of January 3, 2017, Cathrine Chambers contacts Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette via phone. Ms. Chambers feels it is important to update Ms. Doucette on the information Lionel Desmond shared with her on this date. Lionel Desmond reported to Ms. Chambers that he had an argument with Shanna Desmond on New Year's and she told him she wants a divorce. Essentially, things have not been going well since the argument. Ms. Doucette's progress note reads: *"The afternoon of 2017-01-03 this writer received a call from Cathrine Chambers, counsellor, who is now seeing veteran for trauma therapy. She said she wanted to keep CM in the loop about changes in the veteran's situation. They had telephone contact today. He shared he had a verbal dispute with his wife on New Years' Eve, after which she would have told him she wants to divorce. The veteran told his counsellor he went to the hospital as per his wife's recommendation (New Year's Day) and was discharged yesterday. He said he is now staying with an aunt, still in the Monastery area. They had a brief chat about housing; a conversation they would continue at his (confirmed) appointment Thursday, January 5. Ms. Chambers engaged the veteran in conversation about personal safety and he assured he would not hesitate to return to the hospital if he felt a need for immediate assistance. Writer suggested Ms. Chambers obtain from the veteran, at this week's appointment, consent to communicate with his CCM (whose services she was already aware of) about housing and other resources that may be needed. She agreed this was a good idea. Ms. Chambers confirmed that so far, she and the veteran had two in-person sessions, and spoke over the phone. CM thanked her for the information and indicated she would be contacting the veteran as soon as possible."*	Exhibit P–000117 [page 6]
January 3, 2017		Nicole Mann, Executive Director of the Naomi Society, receives a call from a caller believed to be Shanna Desmond at 3:00 p.m. The Naomi Society is a not-for-profit organization which provides services primarily to women and children who have experienced domestic or intimate partner violence in the Antigonish and Guysborough areas. The Naomi Society is funded by the Department of Community Services through the Nova Scotia Status of Women and is a member of the Transition House Association of Nova Scotia. Naomi Society provides services including counselling,	Exhibit P-000078

	support work, and court accompaniment. Counselling can involve healthy relationships, domestic violence, the cycle of violence, and the effects of violence on children. Although the caller did not identify herself the caller display read "Shanna Desmond." Nicole Mann completed a "One-Time Contact" form outlining the specifics of the call. Ms. Mann recorded the reason for the call under "**Description of present situation**" as follows: *"Client called requesting information on a Peace Bond. Client noted her ex-partner was in the Military and has been discharged noting her* [*sic*] *has mental health issues and has PTSD. She noted she felt like she should have some concerns for her 10-year old daughter if he was unfit to remain in the military."* Ms. Mann recorded the nature of the advice given to Shanna Desmond as follows: *"Worker provided information on Peace Bond. As conversation evolved; worker spoke about Family Court Orders, Legal Aid, Summary Advice, and provided client the nsfamilylaw.ca website. Worker talked about referrals in the event she feels her child is unsafe with her ex-partner; client noted she is not at this point. Worker informed client of services and noted she was welcome to come schedule an appointment if she would like. Client noted she would give it some thought*." The source of the referral to Naomi Society was not known. No other services were noted as having been accessed. There was no mention of weapons being used or threatened. When asked if she wanted to schedule an appointment Shanna Desmond indicated she would think about it. The call lasted approximately 20 minutes. This document was provided to the RCMP on January 4, 2017.	
	Ms. Mann did not ask about a history of domestic violence or probe too deeply into the caller's relationship with her partner. Ms. Mann explained that this is not done in a call such as this when the caller is seeking information as the focus at that point is on whether the caller is safe at that moment and they are attempting to "keep the	Transcript February 25, 2020 [page 163]

	door open." The caller did not seem to be in crisis at the time of the call. A formal risk assessment tool (such as ODARA or Jacquelyn Campbell Danger Assessment) was not used at that time. No other agency including the RCMP had completed a risk assessment tool.	
January 3, 2017 **4:00 p.m.**	At approximately 4:00 p.m. on January 3, 2017, Lionel Desmond attended Leaves & Limbs Sports Outpost located at 4167 Trunk #4, Lower South River, Antigonish. Store video surveillance showed Desmond wearing Carhartt pants, green hoodie, black work boots. Upon entry at approximately 4:00 p.m. Desmond is seen browsing the firearms section of the store. Lionel Desmond remained in the store for approximately 22 minutes before he is seen walking off camera towards the cash with store owner Dan Kulanek at 4:22 p.m. Dan Kulanek described Lionel Desmond as "very polite and outspoken," "well-mannered, well dressed, casual and relaxed customer." There was no impression of any concern. There is nothing in the video to suggest Lionel Desmond was in any hurry or that he showed any signs of anger, frustration, or duress. Kulanek indicated that Desmond had been familiar to him as he had been in the store two (2) to three (3) times prior looking at firearms. He estimates that it would have been two (2) to three (3) weeks prior to this date. Desmond first looked at .22 caliber rifles prior to picking out and deciding to purchase a SKS 7.62 Model 2210 SN # PN6162 (non-restricted). This firearm was converted with an ATI stock and detachable magazine that held five (5) rounds. Originally Desmond is observed having trouble operating the firearm bolt. Kulanek is observed demonstrating to Desmond how to remove the magazine and release the bolt that was locked back. Lionel Desmond is then observed on video looking at cases for the firearm. Ultimately, none of the available cases would fit and the gun is sealed in a box by Kulanek. Desmond can be seen carefully placing the unpurchased cases back on the shelf. Lionel Desmond also asked about ammunition. He is first shown the cheaper surplus full metal jacket ammunition by Kulanek and is advised that this ammunition would eventually corrode the	CAN001401 CAN001479 CAN000258

	firearm if not cleaned properly. The cost of this ammunition was $3.00 to $5.00 per box and contained 25 rounds. Lionel Desmond decided to purchase the more expensive ammunition, a box containing 50 rounds of Hornady 7.62 at a cost of $50.54. This ammunition was described by Kulanek as less corrosive. In addition to paying $50.54 for the ammunition Lionel Desmond paid $450.00 cash for the SKS 7.62 Model 2210 firearm. The receipt for the ammunition had a recorded time of 4:15 p.m.	
January 3, 2017	Chantel Desmond receives a call from Aaliyah Desmond between 4:20 p.m. and 4:30 p.m. asking Chantel Desmond to pick her up. Chantel Desmond was in New Glasgow at the time. Upon arrival at the house at approximately 6:00 p.m. Chantel Desmond entered the home and discovered the deceased and called 911.	
January 3, 2017	At approximately 6:00 p.m. S/Sgt. Maccallum was at the Guysborough Detachment when he overhears a call from the Truro dispatch centre to the member on duty at the time, Cst. Nathan Sparks. The call was of a "suicide in progress." The address given was a civic number on Highway 16 in Upper Big Tracadie. A 9-1-1 call had been received from Chantel Desmond. S/Sgt. Maccallum was familiar with the residence in question which he knew to be a mobile home with foundation. S/Sgt. Maccallum responded to this call with Cst. Sparks. He explained that it was typical to have at least two (2) members respond when the call indicated a crime of violence in progress or a traumatic event. As they travelled to the scene, they learned that this matter involved multiple deaths and that a firearm was involved. The officers learned that the matter involved Lionel Desmond and Shanna Desmond. Lionel Desmond was known to S/Sgt. Maccallum at the time, having had the previous dealing with him in November 2015. The officers arrive on scene at 6:28 p.m. Upon arrival there is a group of people in the driveway. The officers now understand that there are three (3) to four (4) deceased. The officers' intention was to make entry and clear the residence. They understood from speaking to John Day that Lionel Desmond was the likely shooter and that there was a long gun laying next to him. Upon entry the officers discover the four (4) deceased. Lionel Desmond is dressed in camouflage. There is a rifle laying over his	Exhibit P-000020 CAN001391 [pages 1 – 3]

	left arm close to his chest. The officers observe numerous spent shell casings. Emergency Health Services (EHS) arrived and "staged." Other RCMP members arrive to assist with scene security and containment of the crowd that had gathered. The RCMP Northeast Nova Major Crime Unit and the RCMP Forensic Identification Services were anticipated.	 Transcript January 28, 2020 [page 61]
January 3, 2017	Cpl. Gerard (Jerry) Rose-Berthiaume of the RCMP Northeast Nova Major Crime Unit is assigned as primary investigator and arrives on the scene at approximately 9:00 p.m.	
January 3, 2017	Dr. Erik Mont is a forensic pathologist employed with the Nova Scotia Medical Examiner Service as Deputy Chief Medical Examiner. The office of the Chief Medical Examiner was called at approximately 8:20-8:30 p.m. The call was taken by a nighttime investigator.	
January 4, 2017	A determination was made that Dr. Mont would personally attend the scene in Guysborough, Nova Scotia. Dr. Mont and his team of two (2) medical/legal investigators arrived at the scene at approximately 1:15 p.m. After consultation with the RCMP Identification Section they entered the home at 2:30 p.m. Dr. Mont explained that in circumstances such as this the police have jurisdiction over the scene and the Chief Medical Examiner's office has jurisdiction over the bodies of the deceased. When they entered the home the police had already processed the scene. Upon entry, Dr. Mont observed four (4) individuals, each of whom had appeared to have sustained gunshot wounds. The bodies of the deceased did not appear to have been moved. Dr. Mont was at the scene for a little over two (2) hours. The bodies of the four (4) deceased were removed from the scene and taken to the office of the Chief Medical Examiner for post-mortem examinations. In each case a determination would be made as to the cause and manner of death. The cause of death is defined as the disease or injury that, in an unbroken chain of events, ultimately leads to a person's death. The manner of death is a statistical classification in which deaths are classified into one (1) of five (5) categories: homicide, suicide, accident, natural and undetermined.	Transcript January 30, 2020 [pages 19 – 20] Transcript January 30, 2020 [pages 22 – 24] Transcript January 30, 2020 [page 13]

January 4, 2017	All of the initial investigators, the entire RCMP Northeast Nova Major Crime Unit and members from the Forensic Identification Services are on scene for briefing. Members are assigned tasks as part of the investigation. RCMP members soon began to piece together the chain of events immediately preceding the tragedy. Cpl. Rose-Berthiaume described what they learned as follows: *"And that really brings me to the information we learned about New Year's Eve. Based on the investigation, I believe and the investigators believe that kind of set this chain of events in motion. And that on New Year's Eve, Lionel along with his family members and Shanna, were at a party at a family cabin. Everything went really well that night, everyone had a good night from all accounts.* *However, on the way home, Lionel was driving Shanna's truck, it was a new truck that Shanna had purchased, and on the drive home the roads were icy and Lionel subsequently put the truck off the road. No one else in the vehicle thought it was a big deal including Shanna, it was her truck and she seemed to just brush it off, but Lionel was really, by all accounts and numerous witnesses had told us he was really bothered by this and just wouldn't let it go. He was very upset, he was very embarrassed and that carried on for the drive home. Shanna drove home after the truck got out of the ditch and it carried on all night and basically where no one got any sleep in relation to this truck going off the road to the point where Shanna asked him to leave and Lionel packed up his stuff and did so.* *We understand from the interviews that we conducted, Your Honour, that on New Year's Day Lionel attended the St. Martha's Hospital and checked himself in the Emerg and was seen by a number of doctors there and actually spent the night there and then was discharged in the morning.* *And from there on Monday, he began the process of packing up some of his stuff. He was back and forth between his house and the Greencorn house. Sandra and Kenny Greencorn were relatives of his who he was very close with and he had stayed before and he was given permission to stay there. So Monday was basically consisted of a couple trips into Port Hawkesbury, him packing up, back and forth to the house. He put some wood in at the MacEacherns' residence.* *Again all this, Your Honour, we're gathering from statements that we've taken from various family members and various*	Transcript January 29, 2020 [pages 48 – 51]

	acquaintances, friends. And he's again engaged in the process of leaving the residence that he'd been staying at, which was the Borden residence, belonged to Thelma and Ricky which is where the incident occurred, and beginning to pack up and basically move into the Greencorn residence. *And that takes us again to the Tuesday, the 3rd. We're aware from interviews conducted and the information that we gathered throughout the investigation that he goes into Antigonish in the morning and there's an appointment made with health services through Dr. Slayter again. And from there, he attends a local outdoor store where a firearm was purchased as well as some ammunition. And from there, we believe he goes back to the Greencorn residence and gets changed because the clothing that Lionel Desmond's wearing on video at the local outdoor store in Antigonish is . . . significantly different from what he had on. There was no one home at the Greencorns' at this time and he changed vehicles. So Lionel had access to two vehicles we learned through the investigation, one was a Mazda and the other was a Ford Escape. He took the Mazda into, based on witness accounts and video surveillance, he took the Mazda into town that day and at the Leaves & Limbs he was wearing like a darker gray jacket and some Carhartt pants.* *Obviously when he arrived at the Borden residence when the incident took place, he was in full heavy camo. So we believe that, and we can't confirm because there was no one home at the Greencorns' at the time, went to the Greencorns', changed and changed vehicles and then proceeded from there to the Borden family where the incident occurred."*	
	The investigation involved numerous components that unfold over the following days. The Northeast Nova Major Crime Unit contacts the National Weapons Enforcement Support Team (NWEST) regarding the weapon found at the scene on January 4, 2017.	Transcript January 29, 2020 [pages 56 - 58]
	Officers learn where the firearm was purchased.	Transcript January 29, 2020 [pages 59 - 60]
	Police make contact with the Naomi Society.	Transcript January 29, 2020 [page 62]
January 4, 2017		

	Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette learns of the tragedy for the first time. A colleague recommends that she contact newly retained Clinical Care Manager Helen Boone. Immediate contact was made. Ms. Boone advises that she last spoke to Lionel Desmond on Monday, January 2, 2017. Ms. Doucette's progress note reads: *"… CM contacted H. Boone, CCM, who confirmed she had last spoken to the veteran on Monday - January 2 by telephone. She provided a summary of their conversation. He was concerned about having to look for his own place given recent conflict with spouse. CCM, who had recently attempted to connect veteran with a local family focused agency (FSENS), revisited his reluctance to engage. She described how the people there could assist with resources such as housing. The veteran ultimately agreed to connect with a particular contact CCM provided once the agency reopened its doors the next day (January 3). She also recommended touching base with his counsellor. They hung up after agreeing to reconnect by phone before the end of the week to see how he had made out."*	Exhibit P-000117 [page 6]
January 4, 2017	After learning of the tragedy, Therapist Cathrine Chambers prepares a five (5) page document titled "**INDIVIDUAL PSYCHOTHERAPY ASSESSMENT FORM**." This document is a retrospective timeline document. Ms. Chambers testified that the entire document was completed by her post tragedy. The document was prepared at the request of Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette. It contains Cathrine Chambers' recollections of her interactions with Lionel Desmond over the brief one (1) month period between December 2, 2016, and January 3, 2017. This document is faxed to Veterans Affairs Canada (VAC) on January 10, 2017.	Exhibit P-000076
January 5, 2017	Kenny Greencorn and Junior MacLellan locate Mr. Desmond's jeep on a woods road near the house. This was reported to police. A statement was taken from Mr. Greencorn on January 5, 2017. Mr. Greencorn was asked if Lionel Desmond had ever talked to him about the problems he was experiencing: *"**Q**. Has he ever talked to you about the problems he was having down the road?* ***A**. Yeah, a few times, like, he mentioned he was having some . . . like the last time he was up here, he said to me, the fir- . . . like*	Exhibit P-000164 [page 6] Exhibit P-000164 [pages 9 – 10]

	when he stayed, they had a little argument over a piece of yarn on the floor. And he said she went . . . was going crazy over it and hollering and going on so he said he had to get out of there. ***Q**. When was that?* ***A**. About a month ago or so or a month and a half ago. The last time he stayed with us.* ***Q**. Kenny, anything else that you can tell us that . . .* ***A**. He told me one time that he had a dream of cutting her head off. And he told this to somebody else, too, he told it to people, like . . .* ***Q**. How long ago was that, Ken?* ***A**. It was a while ago, a couple . . . two, three months ago or maybe longer. Just guessing."*	
January 5, 2017	Police are made aware of the location of the Ford Escape. Four (4) cell phones are seized from the residence by RCMP and sent to the RCMP Technological Crime Unit for analysis.	Transcript January 29, 2020 [pages 66 - 69] Transcript January 29, 2020 [pages 79 - 81]
January 5, 2017	Gilles Marchand, a senior forensic analyst employed with the RCMP, was tasked with extracting the data from the four (4) phones. Mr. Marchand created an Extraction Report dated February 5, 2017, which contained material from three (3) of the four (4) phones. Text messages between Lionel and Shanna Desmond over the preceding days and months show a pattern of anger, suspicion and accusation on Lionel's part, often followed by texts apologizing to his wife. They demonstrate significant conflict and a deteriorating relationship. On January 1, 2017, Lionel Desmond sent the following texts to his wife while at St. Martha's Regional Hospital:	Exhibit P-000099-A to W Exhibit P-000099-I

	"20:23:07(UTC-4) Hey just wanted to say I am sorry for yelling *20:28:59(UTC-4) I am sorry I put my hands up to you i would never hit you…..i am sorry for yelling are business out there . I apologize for aaliyah to hear me outburst…..I'm safe now good night xoxo love you shanna* *20:34:20(UTC-4) Please let me know if I can come home to you ….i was out of my mind I'm calm I should have stayed calm and I said some hurtful things to you please forgive me….* *. . .* *20:39:15(UTC-4) Shanna i am sorry for my actions….if you have time text me i am getting ready to fall fast asleep"* Lionel Desmond's last text to his wife was on January 3, 2017, at 9:49 a.m. It read, "Did aaliyah get to school."	
January 6, 2017	Dr. Mont produced a Medical Certificate of Death for each of the deceased each dated January 6, 2017: a. Shanna Desmond: The cause of death is described as "Gunshot Wounds of Neck, Chest, and Abdomen." The manner of death is homicide. b. Aaliyah Desmond: The cause of death is described as "Gunshot Wound of Face, Neck, and Chest." The manner of death is homicide. c. Brenda Desmond: The cause of death is described as "Gunshot Wound of Chest." The manner of death is homicide. d. Lionel Desmond: The cause of death is described as "Gunshot Wound of Head." The manner of death is suicide.	Exhibit P-000062 [page 1] Exhibit P-000046 [page 1] Exhibit P-000051 [page 1] Exhibit P-000056 [page 1]
January 9, 2017	In an e-mail dated January 9, 2017, from Rob O'Reilly to Derek Eardley, former New Brunswick Chief Firearms Officer, the history of his department's involvement with Lionel Desmond was outlined. In particular, he outlined his department's role with the	Exhibit P-000132

various applications and reviews of Desmond's Possession and Acquisition Certificate. Points of interest include:

1) In reference to the November 18, 2015, Nova Scotia occurrence (RCMP Investigation File # 20151494158) O'Reilly stated the following:

   "This occurrence also generated a FIP notification but was sent to the CFO Nova Scotia, as this was the jurisdiction of the incident. Delays in disclosure by police resulted in the information only being received by the CFO on 14-Apr-2016.The licence was again placed under review while the information was considered, however the medical assessment received in relation to the Nov. 27, 2015 FIP meant the licence was returned to valid on Apr 18, 2016."

2) In reference to the November 28, 2015, Nova Scotia occurrences (RCMP Investigation File #'s 20151539202 & 20151539308) O'Reilly stated the following:

   "Neither of these incidents generated a FIP notification, therefore were unknown to the CFO."

3) In reference to the November 25, 2016, Nova Scotia occurrence (RCMP Investigation File # 20161560270) O'Reilly stated the following:

   "This incident did not generate a FIP notification, and therefore the information was unknown to the CFO."

4) *"The identified issue around the timely disclosure of FIP information to the CFO NS has already been addressed through a specialized unit at the CFP's Central Processing Site in Miramichi, NB. This unit began processing FIPs for Nova Scotia in April of 2016, resulting in immediate notification and disclosure."*

5) *"Strategic Considerations:*
   Improper coding of occurrences in police records management systems will continue to affect the information available to CFOs in making informed decisions around client eligibility to hold a firearms licence."

6) *"CFOs currently place a top priority on addressing all mental health information received, however most interactions with*

	medical practitioners do not come to their attention unless self-disclosed by the client ..."	
January 10, 2017	In the days following the tragedy Veterans Affairs Canada (VAC) Case Manager Marie-Paule Doucette is contacted by her area director. At the request of the Federal Deputy Minister's office she is asked to prepare a chronology of events. This will outline Lionel Desmond's interactions with Veterans Affairs Canada (VAC) and serve as the basis for an internal review. Within this report Ms. Doucette makes the following entry: *"(**** Significant bureaucratic barriers complicated the process to have CCM services started. CM would like to discuss with decision-makers at some point if at all possible)."*	Exhibit P-000299 [page 7]

	As part of the Veterans Affairs Canada (VAC) review and under the heading "**Opportunities for Improvement**" the following 12 areas are listed as priorities moving forward:
	
	"Opportunities for Improvement
	
	Through the process of this review, no procedural errors were found; however, as with any file review, there were opportunities for improvement found on a go forward basis from a national and quality assurance perspective.
	
	• ***Interdisciplinary Team (IDT)***
	    ○ *Consultation could be held to discuss and take action on recommendations resulting from an OSI Clinic. IDT consultation is beneficial in obtaining additional VAC service expertise on how to motivate client.*
	    ○ *National IDT Guidelines will be finalized, disseminated and training will be provided by end of fiscal year 2016-2017.*
	
	• ***Case Management Services***
	    ○ *The length of time to have a case manager in place is a factor to success and rehabilitation of the client. It is noted that hiring and retention process is nowunderway which should improve the turnaround times noted in the file.*
		Exhibit P-000303 [pages 5 – 6]

	• ***Additional Resources***
	  ○ *Consideration of additional supports (e.g., OSISS, group counselling, Soldier On) to assist Veteran in feeling less isolated.*
	
	• ***File Transfer***
	  ○ *Prior to a Veteran's relocation, provide information on local VAC offices, hours of operations and local resources as available.*
	  ○ *More timely transfer of Veteran file to a Case Manager following Veteran relocation.*
	  ○ *Updates to the File Transfer Guidelines to be finalized and disseminated by end of fiscal year 2016-2017. Consideration should be given to having a case conference.*
	  ○ *The guidelines will include specific direction such as, Work Items related to Veteran relocation not actioned within a standard turnaround time will be sent to Field Operations for follow-up.*
	
	• ***Health Related Travel (HRT)***
	  ○ *Promote greater consultation surrounding the HRT decision making process (e.g. inconsideration of family impact).*
	
	• ***BHSOL***
	  ○ *As Clinical Care Managers must be trained and registered on BHSOL prior to working with Veterans, ensure that training is done on an urgent basis for cases that require immediate support.*
	
	• ***OSI Clinic File Closures***
	  ○ *OSI Clinics should conduct file handovers when clients relocate to different geographical areas. Files should not be closed prior to handover. A written procedure should be written, which could include a case conference.*
	
	• ***RRIT/CNCI***
	  ○ *Reinforce existing national guidelines to ensure that these CM tools are completed in a timely manner whenever there is a change in Veteran's health needs or risk factors.*
	  ○ *Through the Quality Assurance (QA) process, proper use of CM tools will be managed.*	

	• ***Suicidality File Review Process***
	  ○ *To be finalized and implemented by end of September 2017.*
	
	• ***Review of Suicide Prevention Business Processes***
	  ○ *Identify gaps in service and update or enhance existing processes by end ofSeptember 2017.*
	
	• ***Follow Up***
	  ○ *Regular file reviews of CM clients to ensure that medical recommendations are taken into consideration.*
	  ○ *Consideration to be given to increase the QA tasks of VSTM's review of CM files.*
	
	• ***CSDN Documentation***
	  ○ *Reinforce the need for timely and relevant notes entered to CSDN."*
	
	Overall, Ms. Doucette agreed that Lionel Desmond was receptive to her role as case manager. He had openly engaged in discussions with her on how his rehabilitation/wellness could be achieved by working with Veterans Affairs Canada (VAC). However, during her testimony, Ms. Doucette expressed what appeared to be a misguided view of Lionel Desmond's condition and its complexity. This bias may have ultimately coloured how she perceived his willingness to follow through with the various recommended resources he so badly needed. Ms. Doucette testified:	

	a. "But I can say that there were times when . . . and this is . . . okay. I'm just being careful with the words that I use because I . . . there were different times during the case management process where it appeared as though some people supporting Mr. Desmond may have been working harder in some aspects than he was with regards to his rehabilitation. *And I say this without any sort of . . . no condescending matter. It happens in a lot of client/professional relationships. And I'm not saying this was consistent throughout the file either but there were times when things were being done for him or presented to him*	Transcript June 22, 2021 [page 238]

	that were probably in his best interest and that he didn't . . . he chose not to go with. And that, again, is the nature of the work that we do. We can't force or do more work than what the veteran will allow."	
	*b. "**Q.** So, with that said, is it fair to say that there is a possibility, looking back, in hindsight, as his case manager, that you might've overestimated what Lionel Desmond was capable of, sort of his level of sophistication to navigate resources on his own or his own expressed independence? Is it possible you overestimated his abilities?* ***A.** At times, yes, it's possible I overestimated. And there were other times where he surprised me because he demonstrated that he was capable."*	Transcript June 23, 2021 [pages 164 – 165]
	c. "There's always room for improvement. I'm not here to debate that point. I want to say that there is a number, many veterans, who we are working with in case management who have some form of cognitive limitation. So absolutely. I was never denying that that was the case with Mr. Desmond. *What I have a harder time getting on board with is this idea that he was more incapable than capable in several aspects because, like I said, I have seen him navigate some things for himself at times."*	Transcript June 23, 2021 [page 165]
	During almost the entire period in which Lionel Desmond interfaced with Veterans Affairs Canada (VAC) he was in a constant state of crisis. He never achieved stability emotionally, mentally, socially, professionally, economically, or within his marriage and community. Any objective assessment of his diagnosis and life circumstances would clearly lead one to conclude that any failure or inability to achieve rehabilitation had more to do with systemic failures rather than a lack of honest and hard effort on his part. The following question posed by Inquiry Judge Warren K. Zimmer highlights the reality of what might have been occurring:	
	"Does it not occur that when people are having difficulty kind of getting through to Cpl. Desmond, it may be as a result of his cognitive deficits as opposed to simply attitude and that it requires some special work to deal with him because of these cognitive deficits that were never fleshed out? Because it seems to me that	Transcript June 22, 2021 [page 257]

	those assessments were never done and actually were never even scheduled to be done."	

See next page for Legend

Legend

Legend	
Canadian Armed Forces Dr. Vinod Joshi Dr. Wendy Rogers	
Cathrine Chambers Helen Boone Family Service of Eastern Nova Scotia	
Family Witnesses Shonda Borden, Chantel Desmond, Ricky Borden, Thelma Borden, Kenny Greencorn	
Firearms	
Guysborough Medical Clinic Dr. Ranjini Mahendrarajah Dr. Luke Harnish Dr. Ali Khakpour	
Dr. Erik Mont	
Naomi Society	
New Brunswick OSI	
Nova Scotia OSI Natasha Tofflemire	
Quebec Ste. Anne's	
RCMP	
Dr. Paul Smith	
St. Martha's Regional Hospital Dr. Ian Slayter Dr. Faisal Rahman Dr. Justin Clark, Leanne Watts, Maggie MacDonald Joan Hines Ellen MacDonald, Amy Collins	
Veterans Affairs Canada and Canadian Armed Forces	