CANADA

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF THE

FATALITY INVESTIGATIONS ACT

S.N.S. 2001, c. 31

THE DESMOND FATALITY INQUIRY

TRANSCRIPT

HEARD BEFORE: The Honourable Judge Warren K. Zimmer

PLACE HEARD: Port Hawkesbury, Nova Scotia

DATE HEARD: April 20, 2021

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EXHIBIT LIST

APRIL 20, 2021

COURT OPENED (09:31 HRS.)

THE COURT: Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Mr. Marshall?

MR. MARSHALL: Yes, sir. Good morning.

THE COURT: Good morning. I understand Mr. Marshall is our first witness, Ms. Ward or Ms. Grant?

MS. WARD: That's correct, Your Honour, and he's ready to affirm.

THE COURT: All right, thank you.

LEE MARSHALL, affirmed, testified:

THE COURT: Ms. Ward? Yes, if you could use the podium, please?

DIRECT EXAMINATION

MS. WARD: Good morning, Mr. Marshall.

A. Good morning.

Q. As you know, my name is Lori Ward and I represent the Attorney General of Canada and that includes Veterans Affairs. So I'm going to be beginning your questioning today and we'll start with a bit of your background.

So you graduated from Memorial University of Newfoundland in 1995 with a Bachelor of Science in Psychology? Is that correct?

A. That's correct.

Q. And you went on to get a Bachelors of Social Work in May 1998 also from MUN?

A. Yes, I did.

Q. And you began your career as a mental health counsellor with youth in Newfoundland?

A. Well, it was a general mental health counsellor in

Newfoundland.

Q. Thank you. And you've done several jobs since then. Could you just run us through? You were a mental health and addictions counsellor as well?

A. Yeah. And I also did a stint in child protection in New Westminster, British Columbia, and then I was recruited by VAC as an area counsellor which is equivalent to a case manager today.

Q. Do you know what year that was?

A. May 1999.

Q. So you did the case manager job, essentially.

A. Yes.

Q. And then you became what is now called a "VSTM"? What is that?

A. Yeah. So today it's referred to as a "veteran service team manager". It's basically the frontline manager responsible for case managers and veteran service agents, so they oversee their performance, quality of their work, support them, and those types of things.

Q. And then you were the acting national manager of client services. Can you tell us about that?

A. Yeah. So, eventually, I was moved to Charlottetown,

our headquarters, in service policy, and after a couple of years as a project manager and a national education and training officer, I became a ... the national manager of client services which was essentially the functional position responsible for case management and other support services in the organization at that time.

Q. And then you became an area director?

A. Yeah. From there, I became what was referred to as a district director of Newfoundland and Labrador and then I did some other positions, such as I did an acting assignment as the director of case management support services as well as the director responsible for our national contact centres. And in April 2019, I took on the role of area director for Newfoundland and Labrador, New Brunswick, and Prince Edward Island, and I was in that position until December 2020, and I'm currently on an acting role as director of corporate affairs for field operations.

Q. So you've done lots of jobs within VAC or Veterans Affairs Canada. I'll refer to them as "VAC".

A. I'm sorry, Lori, I lost your audio then. I can't hear you.

Q. Sorry. I said I'll refer to Veterans Affairs Canada

as "VAC" and I was just saying you've done lots of jobs within VAC. You've been a case manager, you've been a veterans service team manager as well as worked in policy.

A. Yes, I have.

Q. And you had no personal involvement with Lionel Desmond, did you?

A. No, I did not.

Q. So other than to review some summary documents that counsel provided, you have not reviewed his file in Veterans Affairs systems.

A. No, I have not.

Q. Okay. We're going to start. I think the idea is to give a bit of a general overview of what VAC's mandate is and what benefits it offers, so we'll just start with a mention of the legislation. As I understand it, the **Pension Act** came in after World War 1 and provided lifelong disability pensions for wounded veterans. Is that correct?

A. Yes, it is.

Q. And then what happened in 2006 with the legislation?

A. In 2006, we enacted a **Canadian Forces Member and Veterans Re-establishment and Compensation Act** which we refer to as the **New Veterans Charter**, and the major changes with the **New**

Veterans Charter is that we now have legislation to provide rehabilitation services to veterans, and the compensation for disability or illness switched from a lifetime pension to a one-time payout, and that was referred to as a disability award.

Q. And then what happened in 2019?

A. So in 2019, the **New Veterans Charter** evolved and we enacted what's referred to as "Pension for Life" or the **Veterans Well-being Act**, and the **Veterans Well-being Act** basically made some changes to the **New Veterans Charter**. Now, veterans are entitled to compensation or "Pension for Life" for disability or illness. It also tightened up or simplified our income replacement benefits, so we had multiple income replacement benefits and six became one, which is referred to as the "Income Replacement Benefit". And it also sort of honed in our rehabilitation program, just sort of tightening some of our approaches to the rehab program.

Q. So there have been some improvements. In fact, the **Veterans Well-being Act** is really the **New Veterans Charter**, new and improved and renamed, is it not?

A. Yes, it is. So VAC has continually evolved and there were changes along the way to our programs under the **Charter**, but the **Veterans Well-being Act** really solidified some major

changes and simplified the programs for us in a lot of ways. And of course, the "Pension for Life" is one of the more popular additions to the **NVC** under the **Veterans Well-being Act.**

Q. Okay, but when Lionel Desmond was releasing from the Forces in 2015, he would've been under the **New Veterans Charter** regime. Correct?

A. That is correct, yeah.

Q. Okay. I'll just ask you to give us a bit of an overview of monetary benefit scheme. So how does a person apply for monetary benefits after they release from the CAF?

(09:40)

A. So there are really, you know, three streams to monetary benefits. Probably the biggest is compensation for disability or illness, so that's what we refer to as it was, disability pension. It became the disability award under the **New Veterans Charter**, and now it's referred to as "Pain and Suffering Compensation". So that basically is financial compensation, for illness and injury related to service.

We also have financial replacement benefits for income replacement. So in 2015, that would've been referred to as "Earnings Loss". Today, we call it the "Income Replacement Benefits". Basically, what that is is kind of like an income

insurance. While somebody is participating in rehab, we pay ... today, it's 90 percent of their income. In 2015, it would've been 75 percent of their income while they were serving. Whatever that income was, it would be 75 percent of that. And that's really to allow them to participate in the rehabilitation program, although there are components that if someone is determined to diminished earning capacity, referred to it, basically, that we've decided that they're not going to go to rehab to a job that will sustain their lifestyle, then they can receive that income replacement until they're 65 years of age.

And then the third is really reimbursement for services, medical services or treatment related to their injuries. So we reimburse anything from pharmaceuticals, to health professionals, to travel to see health professionals.

Q. Okay.

A. And I'm oversimplifying but, in general, those are the three main ways to receive finances from VAC in today's environment.

Q. So someone with a service-related injury like, say, PTSD, how do they actually apply for a disability benefit?

A. So they can apply at any point in time either during their career or after they retire. Basically, they need a

diagnosis and then that diagnosis has to be associated with their service or aggravated by their service. The vast majority come in as paper applications and, basically, it requires medical substantiation and service records, typically, to associate the illness or injury to the their service.

Q. So when a veteran or a serving member applies for a disability benefit, that person has to submit medical documentation?

A. Yes. Well, we need medical documentation to substantiate that it's a diagnosed condition. It is possible that that diagnosis can occur prior to their release and it might be part of their service medical records but, often, clients will seek out a diagnosis post-service and see a private provider, for example, in the community, to get that diagnosis.

Q. And when they submit documents as part of their application, what happens to those documents?

A. Well, so it depends on the type of document, but most documents submitted for application are scanned into the client service delivery network, which is our electronic system, and they are then adjudicated by our disability folks in Charlottetown.

Q. So once they're scanned into the system, who can look

at them?

A. So our system, which is called "CSDN", or the client service delivery network, has multiple levels of access based on your position. So if you're a disability adjudicator, you can certainly go in and access any of those documents. Case managers typically have access to more documents than, say, I would in my position, and they can technically access service health records, although they've been instructed not to because service health records are considered "need to know" and the service health records are not considered "need to know" documents, say, for case managers but, of course, adjudicators do require those to make decisions around disability awards or pain and suffering compensation.

Q. Presumably, a person applies for a benefit and they get either a favourable decision or they get denied. What happens if they get denied? What can they do?

A. So if someone is denied their application for, say, a disability award in this case, the first recommendation is that they call the Bureau of Pension Advocates which is basically a team of lawyers that work for the Department to represent veterans. So the first suggestion is usually what is referred to as a departmental review. So often claims are denied because

there's not enough information or all the required information isn't included. So, typically, an advocate will review the application with the veteran to see if there is any additional information that can be submitted. If there is, then they can resubmit the disability application for departmental review.

If that's unsuccessful, then they have the option of bringing it to the Veterans Review and Appeal Board. The Veterans Review and Appeal Board is an independent body where a client and the advocate can first bring their claim for a review to the Veterans Review and Appeal Board, and they have the authority to overturn VAC decisions. And they also have two levels of review. So if they're unsuccessful in the first level, they can resubmit for a second review through VRAB.

Q. And then they can go to Federal Court after that if they're unsuccessful through VRAB.

A. That's right.

Q. And will the Bureau of Pensions Advocates provide them with free legal services throughout that process?

A. Yes, it's free legal services to follow them through and they will represent the veteran throughout those processes.

Q. How many times can a person apply for a benefit?

A. There's no limit in terms of someone applying. Of

course, they would require new information, I suppose, but there's no reason they can't continue to apply.

Q. And can they be reassessed?

A. Yes. So once a decision has been made; in other words, it's been determined that their diagnosis is attributable to service, they can submit for a reassessment at any point in time, and that really is a review to see if the condition has gotten progressively worse and, if so, the level of compensation can go up.

Q. Can you just tell us a bit about how the benefit is calculated? There's a five-on-five score and there's a percentage score for a disability.

A. Right. So that's correct. So the five-on-five is attributable to service. So, for example, if the entire diagnosis is attributable to service, then that would be five over five. In other words, the condition is completely attributable to service. It is possible to have a fraction of that; say, one-fifth attributable to service, and I guess what that would basically mean is the condition was aggravated by service but not entirely attributable to service. So that's just how much is connected to their service. And then the second piece is a percentage of disability, and that's basically

the level of the disability. In other words, if the condition is worse, then the level of disability goes up.

Q. So the percentage awarded corresponds to the severity of the condition?

A. Exactly.

Q. And so if you're assessed once - say you're successful and you get a certain percentage for disability - can you ask to be reassessed for the same disability?

A. Yes, you can, and if it's determined that it's higher, then you will get the difference from the original assessment to the new assessment. So if you went up from, say, ten percent to 15 percent, then you would be compensated for an additional five percent.

Q. Is there any time limit to be making an application for reassessment?

A. No.

Q. And is there any limit to the number of times you can ask to be reassessed?

A. No.

(09:50)

Q. Turning to health benefits now, we know that a serving Canadian Forces member has their health benefits through the

Forces. What happens when a person releases and becomes a veteran?

A. So if a veteran is entitled to benefits under VAC; in other words, say, for example, they receive a disability award, then they are entitled to treatment benefits associated with that condition. We call that "A-line coverage" and they get what we refer to as a Medavie Blue Cross card, and that card they can take to a pharmacy, to service providers, and get approved for benefits related to their condition.

Q. So if someone releases from the Forces and they don't seek any benefits from Veterans Affairs, they just go into the civilian system? Like, in Nova Scotia, we have MSI or ...

A. Well, they, depending on their service, they can apply to continue their federal coverage. I'm no expert in that area but, in the same way, if I retired tomorrow, I'd continue to pay into the public service health care program. Some veterans, depending on service, have that option as well. But, yes, in general, they would be relying on the provincial health care system and whatever additional insurance coverage they might have outside of VAC if they did not apply.

Q. So you mentioned a person with a disability benefit would be eligible for some health benefits. You mentioned a

Blue Cross card and you mentioned prescription drugs. How does the prescription drug benefit work?

A. Okay. So, basically, depending on the condition that you have, there's agreed to entitlements in each of the categories, really, of health coverage, but, so for pharmaceuticals, there would be formularies that indicate which medications are typically used to treat that condition. So if they're prescribed a particular medication by, say, a physician, and they go to the pharmacy and they have their Blue Cross card, then, typically, VAC will pay a hundred percent for that medication as long as it falls within their formularies. If it doesn't fall within the formulary, there is a process. It's another unit within Medavie called the "special authorization unit". So they can take that claim or request for reimbursement for that medication to the special authorization unit. Typically, what is required there is further information or explanation by the prescribing entity as to why that medication is required. If it helps, I can give a small example. Typically, we approve generic drugs. Sometimes there are more expensive, potentially new drugs that wouldn't be on the formularies, let's just say, but perhaps a physician has tried the generic drugs, they have not worked, and then they decide to

move to this next drug. The new drug may not be on the formulary, so they have to basically explain why they are ... that they've tried the generic drugs, they aren't effective, and now they're using this new, potentially more expensive or less known drug.

Q. So would a veteran just take that prescription to the pharmacy and find out that it wasn't approved, or would they submit it to VAC first for preapproval, or how would that work?

A. Typically, they go right to the pharmacy and then they're instructed if it's approved or not. If it's not approved, they're given their rights to go to the special authorization unit and that's when they would be required to contact the prescribing physician for additional information but, in most cases, Lori, the prescriptions are approved on the spot, so the veteran just brings in their prescription and they get their prescription filled.

Q. Okay, so if the drug is not, say, on the list of drugs for the stated condition, there might be a delay in getting it approved. Can you speak to how long that delay might be?

A. The delay would really be dependent on how long it takes for the prescribing physician to get the new information in to explain why that particular medication is required, so

there's no fixed timeframe. It really depends on how long it takes the prescribing physician, or whoever the prescriber is, to provide that rationale, and then the special authorization unit needs to render their decision, and once that's done, the prescription can be filled, or the veteran can pay upfront and request to be reimbursed after the fact, and if VAC approves, or the special authorization unit approves the medication then they can be reimbursed for the full cost.

Q. So that reimbursement would date back to the initial purchase.

A. Assuming the rationale substantiated it, yes, the date of the original purchase.

Q. You mentioned that pharmaceuticals were one of many potential health benefits. Can you just speak to what else is on the list of benefits?

A. Yeah. So we refer to them as "programs of choice". There are 14 areas, so it covers everything from aids to daily living, which could be grab bars or a cane, grab bars for your bathroom or a cane, ambulatory services, so that can be payment for an ambulance or what we refer to as "health-related travel", compensation for travel to appointments. If ... so there are 14, but not every condition entitles you to all 14, but we have

vision care, audiology, we pay for medical services, hospital services, nursing services, medical supplies, and other health-related services like physiotherapy, massage, psychology treatment, social work. As long as it's related to the pension condition and they're approved modes of treatment.

Q. So VAC is not a health care provider, per se.

A. No. VAC pays for health care for our veterans, but we don't provide direct health care.

Q. And is VAC the holder of a person's health records?

A. Not typically. VAC would only have health records submitted for programs or submitted in support of a program for a veteran. So, of course, we have some medical documentation associated with, say, application for a disability award, and if a veteran were to participate in treatment, say, within a rehabilitation program, we would require assessments, typically professional assessments, for psychology or VOC specialists to support the rehabilitation program, and then we could potentially have follow-up documentation that support the implementation of the rehab plan.

So, for example, within the rehab plan, if treatment for a particular condition is part of that plan, then we would potentially have assessments submitted to us in support of the

treatment for that plan and that allows us to ensure that the services that we're paying for are being rendered and that we can continue according to, you know, as long as those documents support the rehab plan. But we don't have provincial health records, we don't typically hold on to or review the health records of veterans if they access provincial health entities unless, of course, the veteran asks us and gives us permission to request those and they somehow have value in relation to the programs we're delivering such as rehab, but we do not have the health records of veterans that encompass all health-related interactions.

Q. Okay. So when a veteran accesses provincial health care that's not funded by VAC; for instance, say a veteran goes to an emergency room, would there be any mechanism for that visit to an emergency room or some other provincial service? Would VAC get notice of that or any communication, or would the case manager?

A. There's no formal process for the provincial entities to let us know that a veteran of service has availed of their services and, in fact, you know, we technically don't have the right to know unless the veteran asks for our assistance and advises us that they accessed these health authorities, say,

provincial health authorities. We wouldn't, no.

Q. And so VAC is not a health care provider. I take that to mean it also doesn't have any emergency services.

(10:00)

A. No, VAC operates 8:30 to 4:30. We do currently have the ability to issue some emergency payments in the evening for, say, housing or over the weekend. But, other than that, we provide no emergency services. Certainly no emergency health care services. We would refer our clients to whatever the local health authorities are. Emergencies and police authorities, obviously, in certain situations.

Q. You do also have an 800-number for mental health services, don't you?

A. Yes, we also have 1-800 VAC Assist which is, basically, a short-term crisis intervention, very similar to an employee HELP line. So there are professional counsellors on line. They can provide a limited number of services for anything from, you know, crisis intervention to parental advice to bereavement.

Q. Okay. You had mentioned earlier the rehabilitation program. Can you just give us a little more detail on how that works?

A. Yeah, sure. So the idea of the rehabilitation program is, if a veteran has barriers and, typically these barriers are related to physical or mental health conditions. barriers to re-establishing themselves into civilian life, then they can apply for the rehabilitation program. The idea of the rehabilitation program is the case manager works with the veteran and they collaborate around what those barriers are that are, say, preventing that individual from re-integrating socially from re-integration functionally. So being able to look after themselves or employment. And so it's a collaborative process to work with the veteran and their family to develop a plan. Again, it has to be associated. The associated illness or injury has to be related to service in order to apply for the program and the idea of the plan is that we provide rehabilitation services around physical or mental health conditions and, if the veteran if ready, vocational assistance to help them either re-train or return to civilian employment.

Q. And you mentioned there were financial benefits that were tied to the rehab program.

A. And, in fact, the treatment as well can be a part of the rehab plan. So once you're on the rehabilitation plan, if you require the income replacement benefit or, in 2015, it would

have been earnings lost, you can apply and have your ... Well, in 2015, it was 75 percent of your income. Today, it's 90 percent of your income will be covered by your participating in the program. And also the case manager can approve services or benefits under the rehab plan as long as they're related to the barriers to re-establishment that were identified on the approval of the veteran coming into the rehab plan. So, for example, we could potentially engage in psychological services through the rehabilitation plan in support of removing barriers to re-establishment.

EXHIBIT P-000286 - VAC BENEFITS SUMMARY - DESMOND

Q. Okay, I want to turn now to Exhibit 286. Can you see that document, Mr. Marshall?

A. I can see it now, yeah.

Q. Okay. You've seen this document before?

A. Yes, I have.

Q. But you did not prepare this document. This document was prepared by Veterans Affairs at the request of the Inquiry counsel for ease of reference and you've reviewed it. Is that correct? So you have no reason to believe that this is not an accurate reflection of Mr. Desmond's benefits?

A. I have no reason, no. As far as I know, this is it.

Q. So I just want to ask you to walk us through the document. So this is a summary of financial and health care benefits that Mr. Desmond received. Can you explain the first one there, Adjustment Disability Award Lump Sum?

A. So as I explained before, the disability award in 2015 was a lump sum payment. That would have been compensation for illness or injury associated with service. And, in this case, they reference PTSD. So it is my understanding that that would have been the initial payment for his post-traumatic stress disorder condition.

Q. And then the next one ...

A. And then ...

Q. Go ahead.

A. Sorry, I guess, and the next line looks like he was reassessed and that condition would have been assessed at a higher level. So, therefore, the level of compensation was increased and so he would have received a second lump sum payment for $74,646.99.

Q. Okay. And then it looks like another disability award lump sum.

A. Yeah, so that would have been a different condition that he would have applied for, I assume. That was only

assessed at one time and it's for $15,334.

Q. Okay. And the next thing is Financial Benefits - CIA - Grade 3. Can you explain that?

A. Yeah, so CIA refers to career impact allowance and a career impact allowance or permanent impairment allowance which was, I believe, what it was referred to back then, is basically compensation. So if somebody is awarded a disability, they can potentially also apply for a CIA, career impact allowance, which is basically to compensate them for the impact their injury has on a career progression. So recognizing that the condition would prevent them from, you know, fulfilling or expanding their career, they can receive ... There are three grades of career impact allowance and, in this case, it looks like he was in receipt of Grade 3. So career progression, it is compensating for career progression or lack of career progression, I guess.

Q. Is Grade 3 the highest or the lowest?

A. Grade 3 is lowest of the three. Grade 1 would be the highest level of compensation.

Q. So there are three entries for CIA Grade 3. It looks like covering different time periods. I see a reference to a lump sump and then monthly payments. Can you explain why there is reference to both of those things?

A. Okay, so without actually being in his file, I am really only surmising, but it would appear to me that he applied for the condition but didn't get the decision right away. So the decision was backdated and hence the lump sum. And then he would have continued to receive it as a monthly payment. So unlike the disability award, career impact allowance is a monthly payment.

Q. And the last ...

A. And it can also be ... Sorry, I should also add that career impact allowance can also be reassessed at different points in time.

Q. And the last entry there is for one month, it seems the last month that Mr. Desmond was living, unfortunately. It's 599 instead of 592. Those benefits are indexed from year to year?

A. Yes. Yes, they are indexed and that would explain the difference in the monthly amount.

Q. Okay. Turning to the next little table, it says, Other Financial Benefits. Can you explain to us what SISIP Financial LTD means?

A. Right. So SISIP Financial LTD, this is not our program. This is basically DND's long-term care program. So

this would be service income, security, insurance plans, SISIP stands for. So as I said to you, when you get on the rehab program, in 2015, you would have been entitled to earnings lost benefits. However, medically releasing veterans would have first been entitled to the SISIP LTD program. And SISIP covers income and it also covers VOC Assistance or vocational rehab. And so, in this case, it appears that he was in receipt of SISIP. So he would not have been in receipt of earnings loss benefits from us at that time because SISIP would have been paying 75 percent of his service salary.

Q. And just for clarity, I think you said long-term care but you meant long-term disability.

A. Oh, I'm sorry, I did say long-term care. Yes, it's their long-term disability program.

(10:10)

Q. Okay, and that's a CAF program, Canadian Armed Forces.

A. Yes, it is. It's not our program.

Q. Okay. And then there's a reference to retirement pension. Do you know what that is?

A. I can only assume that would have been income that he received, just regular pension income from his service. But without any details, I don't know. But we would have recorded

... So when someone applies for our Earnings Loss Program, we get a picture of what their current income is. Because, of course, it's evaluated in the context of their other incomes. So my guess is that's his retirement pension from the Canadian Armed Forces, but without having been in the file, I can't say that with certainty.

Q. But if that's so, that would be under the Canadian Forces **Superannuation Act**?

A. It would be.

Q. Okay. Turning to the next page, there's a summary of treatment benefits. You mentioned the POCs to us.

A. Right.

Q. So that's the one with 14 different types of benefits that you mentioned?

A. Yes, it is. Except what we refer to as POC 2 or Program of Choice 2, is ambulatory service. So that's health-related travel in this case. So in reviewing the dates, it appears that he was compensated for his travel on each of those dates. So it was a 46-kilometer run and he received $23 for each of those trips.

Q. So if Mr. Desmond was living in Guysborough and had chosen to avail himself of the services at the OSI clinic in

Halifax, which is quite a drive, would VAC have reimbursed him for the kilometers?

A. Yes, so if it's an approved treatment, typically, we will try to find a local provider but if it's deemed that the provider, say, that's a little bit farther away is the more appropriate treatment provider, and certainly an OSI clinic would fit as an appropriate treatment provider, we will compensate for, not just mileage, we'll pay for meals. If the individual is required to say overnight to attend an appointment, we will pay for overnight and, in some cases, we'll pay for somebody to attend the appointment with him. So we'll compensate an individual for attending or, you know, driving with the individual to their appointment.

Q. Okay, so POC 7 says medical supplies.

A. Right. So that encompasses basically any, well, medical supplies that would fall under the pension condition for the individual. So, for example, if someone required bandages or something like that, they could fall under medical supplies. In this case, it was a vaporizer, claim for $300, we paid. So I would ... The vaporizer is, no doubt in support of the cannabis for medical purposes and we would pay for the vaporizer as we would consider that a medical supply in support of his cannabis

for medical purposes.

Q. Okay, and POC 10 says prescription drug. We know that Mr. Desmond had several prescriptions but there's a reference here to an authorization. So this would be the drug that required the special authorization you were talking about. Is that your understanding?

A. It would be my guess because it's identified as such. So, you know, again, without being into the file, it was authorized to be approved. So that would indicate that it was a special authorization for that medication. So, yes.

Q. Okay, CMP, I think you just mentioned. What's that again?

A. Cannabis for medical purposes. So there are multiple authorizations for five grams of cannabis per day were reimbursed, or he was approved and reimbursed for the five milligrams of cannabis a day for the dates given there. June 6th, 2015 to September 2015 and October 1st, 2015 to September 30th, 2016.

Q. For a total of $15,805.23.

A. Yes.

Q. Okay, turning to POC 12, Related Health Services. Can you just go through those for us?

A. Right. So the first one there is a clinical care manager, November 7, 2016. Service and travel were authorized, a hundred occurrences approved and six occurrences used for a total of $1657.50. So a clinical care manager is a special service that we use in certain cases when we're case managing a client and it's obvious that he was approved for a clinical care manager and that we had authorized a hundred sessions. The occurrences tend to be for 30 minutes at a time. So that would be 50 hours of services for a clinical care manager were preapproved and six were used.

Q. Okay, what's the next one?

A. So November 7th, an authorization was approved for 16 occurrences of counselling therapist, individual visits, and a report. Three occurrences were used and a report provided for a total of $420. So this could be a social worker or a psychologist that was authorized to treat the client. And you can see we approved 16 occurrences and so we would have paid for the report, which would probably be an initial report and then follow-up occurrences to see that whoever was providing the treatment, and it's not indicated there but, obviously, it was a counsellor. And it's not uncommon for us to request reports at the beginning because we use these reports to guide our

rehabilitation plan.

Q. And it was approved for 16 occurrences. Could that be extended normally or how does that work?

A. Yes. So, basically, depending on the situation, you approve a certain number of occurrences that allows the treating counsellor to assess, develop their plan with the individual, and then they can resubmit further reports to extend their services. It's very common for us to do it in this way because, as you can imagine, the treatment ... Well, the assessment and plan for treatment and then the subsequent treatment guides a rehabilitation plan and so, just as the plan is an ongoing living document, we require updated reports, et cetera, to support that plan. So it's very common for a limited number of occurrences to be approved. I say limited. Sixteen occurrences, you know, is multiple visits and would have given plenty of opportunity to assess and begin treatment with an individual and, in all likelihood, that would have continued.

Q. Okay, and the next one is from June 2016, massage therapy.

A. Yeah. That one is pretty standard. He would have received massage related to his pension condition and he would have been reimbursed. Actually, in all likelihood, he wouldn't

have had to pay. The massage therapist would have charged VAC directly. And then November 16th, sorry, 2015. Social work visits were authorized. Three visits were paid totalling 406. So, again, social work, just like counselling, just like massage, just like clinical care managers, are part of our related health services and he would have been approved related to his pension condition.

Q. Okay, and it doesn't appear on this document but we're well aware that Mr. Desmond availed himself of the services of the OSI clinic in New Brunswick, as well as Ste. Anne's Hospital inpatient stays. So those would be considered VAC health benefits as well, would they?

A. Yes. The situation there is a little bit different because, basically, VAC has an arrangement with the provincial health authorities and we fund the provincial health authority who provides the OSI clinic services really across the country. I believe there are 11 across the country. So, in New Brunswick, it would be Horizon Health and we don't, when it comes to veterans attending the OSI clinic, we don't do it on a fee-for-service basis. Basically, they take on the clients because of that arrangement and so we don't get monthly billing related to it.

Q. Okay, I want to move on now to some more about VAC.

A. Sorry, Lori ...

Q. Oh, sorry.

A. If I could ask you to repeat. I think when you move, if you move a little bit away from the mic, I don't get your voice, I'm sorry.

Q. I've got to stay close to the mic. So I was just saying we'll move on now to a little more about VAC and how exactly a veteran would get in touch with VAC and there are various ways. Can you tell us about that?

(10:20)

A. Right. So you can get in touch with VAC, you know, realistically in three ways. You can call us at our NCCN line, National Contact Centre line. You can come visit our offices and we have offices across the country. We refer to it as our area offices. And then you can also use our MyVACaccount, which is our digital platform and veterans can access information about their files on that digital program but there's also a mechanism called "secure messaging" where, basically, you can ... It would be very similar to email. A veteran at any point in time in the evening can submit a question and through secure messaging and VAC will respond to it accordingly. It will

either go to the national contact centre but if it requires, say, a case manager level response, it will go to the case manager or veteran service agent.

Q. VAC also has a website that anyone can access, is that right?

A. Yeah. So all of our benefits are explained on our website and we have multiple tools there as well. You can create your own personalized manual of VAC benefits based on your particular characteristics. You can basically explore any of our programs. And the way it's laid out, you basically talk about what your issue is and the website will lead you into VAC programs and how to contact or how to apply for those programs.

Q. So can spouses and family members avail themselves of the website, too?

A. Yes, they can. It's a public website so anybody can access it.

Q. So you talked about NCCN, which is the National Contact Centre Network, and that's an 800-number the person calls?

A. Yes, it's an 800-number and it's available 8:30 to 4:30, based on your time zone. There are five contact centres across the country and any one of those contact centres can

receive your call. So the idea, just as an example this year, we answered more than 80 percent of our calls within a two-minute timeframe and, at VAC, you get a live person. There is a visual message where you identify why you're calling and then that directs you to the National Contact Centre. But you get a live voice and the NCCN's responsibility is to provide information. They can do, you know, some problem-solving with individuals, how do I apply for this, this is where the application is, here's how you do it. If the caller requires a more in-depth response, then we transfer the call to our second tier of calls, or call queue, and that's called the first contact resolution queue and that is our veteran service agent group and they have a little bit more program authority and they also are able to help with more specific issues or problems. I can explain that more if you want but go ahead.

Q. Well, just before you do that, let's talk about who actually answers the phone when you call the NCCN?

A. Right. So the NCCN analysts are generalists. They have a lot of training with respect to all of our programs and benefits. We have a pretty good communication mechanism. So say, for example, if a new program is announced, the NCCN will typically have a list of questions and answers already provided

to them. So if a caller sees on the news something was announced, the NCCN can usually walk them through that announcement and what it means for them. They will tell you how to apply for a benefit. They can tell you if you're ... If you call and wonder if your cheque is coming or what's happening, you know, with your disability award application, they can give you an idea of where it is in the queue, talk about turnaround times, those types of things.

Q. And you talked about the fact that everybody gets a live person.

A. Yeah.

Q. So is there any sort of voicemail option or anything or is there no voicemail at all?

A. So our case managers and veteran service agents do have voicemail but what we try to do is resolve the question or concern with a live voice before that. So if the NCCN, as an example, analyst can't answer the question, they can transfer the call to the first contact resolution group, which is another call network of our veteran service agents and they're locally based. So if you call Nova Scotia, you're going to get the veteran service agents in Halifax. So not only do they have VAC program authority but they have familiarity with provincial

programs and services, like long-term care or the provincial health authority that provides, you know, home support, those types of things. So instead of leaving a voicemail, what the NCCN analyst will do is what we call a warm transfer. So they'll connect with a VSA, veteran service agent, in that queue and say, you know, I have Mr. Marshall on the phone, he has a question about this, I'm not able to answer it, can you help him out. And then the veteran service agent can access that individual's file through the client service delivery network. They'll receive the call and they'll walk the veteran hopefully to a resolution of their problem. Sometimes it's an application for a program and so they may not be able to approve the program there on site but, once they've talked to the VSA, that application is in process. If the call were even more complicated and it was deemed that a case manager was required, then the VSA would either transfer the call to the veteran's case manager or, if they didn't have a case manager, we also have an intake case manager, who would be able to receive the call and answer more case management-type questions for the veteran. But the idea is that if the veteran doesn't want to leave a voicemail, they don't have to.

Now there are cases. So say, for example, if you have a

case manager and you've been working with that case manager and you called the NCCN and say I want to talk to my case manager, they'll transfer that individual to their case manager and, if that case manager isn't available, say they're with another client, then they can leave a message. But we offer them the choice of, do you want to leave a message or would you like to talk to a back-up or an intake case manager.

Q. Okay. So if the analyst who answers the phone can't answer the question and needs to transfer the person to a veteran service agent, you mentioned that they get on the phone with the next VSA in the queue and they keep the veteran on the line?

A. That's right. So we refer to it as a warm transfer but the goal is that we don't just drop the veteran into another call queue. What we do is we say, Okay, I'm going to call a veteran service agent for you and I'll get them on the phone and then I'll transfer you over. So, basically, the veteran is on hold for a temporary period of time while the NCCN analyst reaches a veteran service agent. They explain to the veteran service agent why they're transferring te call and then they'll reconnect the veteran and say, you know, Mr. Marshall, I'm transferring you to Lori, who is a veteran service agent, and

she's going to help you with that application for long-term care. So the idea is is we just don't release them. That we sort of do a, well, we call it a warm transfer.

Q. So you mentioned a veteran service agent and some of the things they do. I think you mentioned they have a familiarity with long-term care and things like that. What are the qualifications of a veteran service agent?

A. So if we're talking 2015, I think education-wise they required a secondary school diploma but we were recruiting people who had experience in client service or health-related areas. Truthfully, we often recruited people with degrees, social workers, et cetera, who are trying to become a part of the VAC and they will apply as a veteran service agent with the hopes maybe down the road of getting a case manager position, et cetera, but a wide range of skills and abilities.

So veteran service agents have more in-depth knowledge about our programs. They have program authority for things like the veteran's independence program, long-term care. They can help veterans with POC 13, which is special equipment related to, say, their pension condition. They will also do referrals to community resources, et cetera. So they're the next level of support between the NCCN, say, and the case manager group.

Q. You mentioned the Veterans Independence Program and I don't think we talked about that before. Can you tell us a bit about that?

A. Sure. So the Veterans Independence Program has been around for many years and the intent to that program is to keep veterans independent in their own home. It was really developed as a program towards the elder veteran who may be having difficulties staying at home, looking after their grounds, housekeeping, meal prep, those types of things. So that program is, as it's referred to Veterans Independence Program, is intended to keep veterans independent in their own homes for as long as possible by providing supports.

(10:30)

Q. Okay. And you mentioned that veterans service agents, they're equipped to do a bit more than the analyst who answer the phone, but not quite as much as a case manager. Would a veterans service agent take on a veteran for a particular project or period of time or service? How does that work?

A. Yes, they can. So veteran service agents often have sort of longer-term relationships with clients where they support them and help them with their programs. The idea is if you consider a veteran who, say, has some independence, has some

ability to make their own decisions and problem solve but require some ongoing support, veteran service agents will often provide that.

A couple of years ago, we formalized it and we called it "guided support". So guided support is the responsibility of veteran service agents and it's a specific service where the veteran service agents works closely with a veteran for a period of time to help them with a specific issue or concern.

We also used guided support sometimes to assist veterans who are coming out of case management. So if a veteran has reached their case management goals and is disengaging from the case manager and the case management process, we'll offer then guided support which is basically we'll connect them with a veteran service agent who will touch base with them for a fixed period of time and just connect with them to make sure everything is going all right, do some problem solving with them, et cetera, until the veteran is ready to just move on and be completely independent on their own.

So veteran service agents have been ... well, we formalized it in the last couple of years. Veteran service agents have been providing that kind of hands-on support to our clients for many years and it's a big part of what they do, problem-solving,

helping with applications, et cetera.

Q. Okay. And we talked a bit before about veteran service team managers or VSTMs. And you were one of those once. What are their qualifications and what do they do?

A. So their qualifications are ... well, most of them, they have to have a degree, but not a specific degree. They have to have experience in people management, in financial management, performance management, those types of scenarios but what they do is they support the front-line team. So they provide advice and guidance, they help problem solve, they do quality assurance of their work, performance management. They will also often problem solve. Say if a client wants to make a complaint, formalize a complaint, or talk to somebody at the next level, typically they would talk to a veteran service team manager.

Q. Moving on to case managers. How does a veteran get a case manager? Who gets a case manager? How does that work?

A. Okay. So case managers are really highly-skilled individuals. Typically, they tend to be social workers, nurses, occupational therapists. We do have case managers who say have, you know, a degree in psychology, but have years experience in providing case management services probably through Corrections

or something of that nature.

And so the role is really to support a veteran who's at a place in their life where they're faced with, say, a barrier or a complication and they need, you know, more in-depth support to overcome or move through that. So the easy example ... or the most common example, I suppose is a better way of saying, is a veteran transitioning out of the Forces and his transition to civilian live is going to be complicated by a health condition, whether it's physical or mental and they're going to require additional support to basically ensure that they've reduced or removed any barriers that are preventing them from that smooth transition to social integration, employment and/or, you know, functioning.

They can also work with ... it doesn't have to be somebody transitioning out of the Forces or the RCMP. It could be somebody who's faced with a particular, you know, health condition or change in their life that's having a major impact. And in those cases, they can engage in a case manager. And if it's deemed that they require that in depth service, then they will work with a case manager for a period of time.

It tends to be for a fixed period of time. Case management is not something somebody should require throughout their life.

It's a period of time where they require additional support. And, really, the goal of the case manager is to help the veteran or the released RCMP member build their skill-set so that they can handle problems/crises on their own and be more independent.

So the second piece I would say to that, Lori, is that if you apply for a rehab program and get on our rehab program, if you're on the rehab program, you require case management as part of the requirement for the rehabilitation program. So anyone on rehab would also move to the case management cycle.

Q. So are most of the people with case managers in the rehab program?

A. Yes. The vast majority of our case managed clients today are in the rehab program. But we do have clients that are not, for example, RCMP who might require service, and other veterans. But the vast majority are in the rehabilitation program.

Q. So how do you get the case manager and how ... how is the case manager assigned to you and what's the mechanism? Like I might be going to the rehab program, but how does it work?

A. Right. So, typically, case managers are assigned by the veteran service team manager. So when a new case comes in ... and cases can come in or clients can be identified in many

different ways. Today, we have a really good relationship with the Canadian Armed Forces and we work hand in hand. So, typically, when somebody is releasing, we're aware of their release and their release needs through our screening process, and we've identified through, say, a transition interview that that veteran is going to require case management. And so a work item is generated. The veteran service team manager will assign that work item for case management to a particular case manager based on their ability to take on work. We try to have them work in geographical areas, but it's not a requirement. Someone could be case managed by somebody outside of, say, a geographical area if necessary.

Q. You mentioned a "work item". What exactly is that?

A. Okay. So a "work item" is basically an electronic action item. So if I want somebody to do something, I can create a work item which is in our client service delivery electronic system the CSDN and I can assign that work item to that individual. If I don't know who to assign it to ... so say, for example, a new client comes in. He's identified by a veteran service agent as requiring case management. A work item will be generated and that work item will go into a queue and the Veteran Service Team Manager will go through those and

assign them accordingly for case management.

Work items can be used as bring-forwards. If I wanted to make sure I followed up with you in three months, I would assign myself a work item. They can also be created automatically. So if you move and we change your address, that will create a system-generated work item that will go to the area office to notify you that Lori has moved. And whatever area you have moved to will get that working.

Q. So once you get a case manager and you move, do you get a new case manager or how does that work?

A. So if you're in case management and you move typically, we try to assign you to a new case manager in the new area and there's a process between veteran service team managers and case managers to hand off that case. In general, the process happens fairly quickly after an individual moves but there are exceptions.

Say, for example, if it was a temporary move, we may not reassign a case manager if we knew that the veteran was coming back. If the veteran was in rehabilitation and that rehabilitation plan was ready to be closed, then we wouldn't necessarily reassign the client. We may allow the existing case manager to continue to finish and close out that.

(10:40)

And then there are also exceptional circumstances where, say, in a situation where we felt that a reassignment might have a negative consequence on the veteran, we may decide to hold off on a transfer for a temporary period of time until whatever the situation is can be resolved or stabilized before we hand off.

Q. So you mentioned the goal is to transition the person to a point where they don't need case management. How does the case manager go about making a plan or a program?

A. It's an important point. The case manager doesn't develop the plan on their own. It's very much a collaborative process with the veteran. And, hopefully, the veteran's family is also engaged in that conversation. And so, really, the barriers and the goals of the client are identified and become part of the plan.

We also rely very heavily on specialized assessments depending on what the condition is, from health providers in the community; for example, psychologist and/or our VOC rehab specialists and their assessments make up part of that plan and identify what the specific goals need to be to address those barriers and get that veteran to the most independent level they can be.

Q. How would ...

A. And ... go ahead.

Q. I was just going to say, how would a veteran's family become involved in making a plan?

A. So we invite the veteran to involve their family in the plan. We can't engage family on our own. We need the veteran's permission to do that. So really from the very beginning, from the transition interview to the engagement in the case management process, we typically invite the veteran to invite and include their family in those conversations.

If a veteran decides that they want a family member to be able to act on their behalf, they can fill out a form with VAC that says, you know, My wife has the ability to call and ask questions about, say, my rehab plan. But, in general, we deal directly with the veteran unless we have special authorization from the veteran to deal with a particular family member.

Q. Okay. You mentioned it's a collaborative process. So the case manager is not telling the veteran what they should do.

A. No.

Q. How does that relationship work? How do they do up and make a plan?

A. Right. Case management is very much a voluntary

process. If the veteran is not engaged, then, really, case management can't move forward because many of the action items are based on the veteran's own actions and participation, whether it's participation in treatment, whether it's following up on particular specific tasks they've been assigned. So the process is really ongoing.

There is an assessment process where the case manager and the veteran and potentially the veteran's family sit down and they go through a comprehensive psychosocial assessment with the veteran to identify sort of what their particular issues are, their perceptions of what their barriers are, what they've been struggling with, where they feel they need support.

We will use additional ... particularly in the rehab program, we will use additional assessments; for example, an assessment from a psychologist in the development of those goals. And it's an accumulation of those conversations where the veteran and the case manager agree to a plan. And that plan would have what we call "smart goals", so specific measurable goals that are identified to basically reduce or remove the barriers that are preventing the individual from re-establishing themselves into civilian life.

Q. Just returning to the call centre for a minute. If I

have a case manager and I want to get in touch with them, would I call them directly? Would I call the NCCN or how does that work?

A. So we leave it to the case managers to make that decision. So some case managers will hand out their direct line but any veteran can phone the NCCN at any point in time. Our electronic system, the CSDN, identifies that a veteran is case managed and they will identify who that case manager is.

So if a veteran is case managed and they call the 1-800 number and say, I want to speak to my case manager, the NCCN will transfer them through to the case manager. They will often ask, Is there something I can help you with first? But they don't ... you know, they don't prevent that call from going through. They will transfer that call to the case manager.

The reason the NCCN is useful is because our case managers spend a lot of time talking to clients and talking to providers and traveling to visit veterans in their homes, et cetera, and so they aren't as accessible as, say, the NCCN is. And so the NCCN offers that live voice to ensure that the veteran gets a live voice versus voicemail if they call the case manager's line directly.

Q. What happens when your case manager goes away, say, on

vacation or ...

A. So ...

Q. Even case managers get vacations. So what happens then?

A. That's right. So there are a multitude of responses to that. It really depends on their situation. So if you had a client that was in a very intensive acute period, you may ask another case manager to follow through and be the contact for that veteran for that period of time because you know they're going to call multiple times.

You might also call the veteran and explain to him that, Look, I'm going to be away for two weeks. While I'm away you can speak to this person. But, as I indicated before, we also have an intake mechanism. So you don't necessarily need to speak to your specific case manager if you need something actioned. So if an approval needs to occur or if you're in a crisis situation, we can transfer your call to a live case manager who will help you with whatever that situation is.

Q. What are the qualifications of a case manager?

A. Case managers tend to be social workers, nurses, occupational therapists. They can have Bachelor degrees in human or social behaviour; say, for example, psychology,

sociology. But they also require significant case management experience. And so I've personally done a lot of the recruitment for case managers and we tend to end up recruiting social workers, nurses, and occupational therapists because their skill-set, their competencies, and their work experience in case management prepares them for the case manager job.

Q. So they have to have experience in case management before they come to VAC. Is that right?

A. Yes. Yeah.

Q. And what sorts of experience do they come with? Like do you typically hire them from certain sectors or ...

A. So it really depends on the local environment. My experience in Newfoundland and Labrador, New Brunswick, and Prince Edward Island is we recruit a lot of people from the province's child protection entities. We get a lot of people from ... well not "a lot", but we get a fair portion of people from Corrections. And then we'll often get community health providers like community nurses or OTs that work for provincial entities.

Q. So they come with significant experience. And what sort of training do they get from VAC when they arrive?

A. So VAC has what we call our national orientation and

training plan. So there are two pieces to the plan. There's foundational and functional training. So when they come in through the door, they're assigned to the foundational, which is basically ... teaches them what it is to be a public servant, what they need to know about their job and their systems. And then they get into more functional training.

So NOTP will teach them our policies, our business procedures. We also have components that talk about mental health. We go over our suicide protocol. We have a program called "CAF 101", which teaches them the basics of what they need to know about the military. And so it's a combination of online courses and, before the pandemic, in-person courses to prepare them for the generic what they need to know to be a case manager.

We also provide ASIST training, which is the applied suicide intervention technique training, which is an international program recognized for suicide intervention. And we run all of our staff through that program.

Q. You mentioned a suicide protocol as well. Can you tell us a bit about that?

(10:50)

A. Yeah. So the suicide protocol is VAC's protocol. It

basically walks staff through how to identify risks, what to do in the event of identified risks, basically how to deal with suicide in the Department. And it is a great addition to the ASIST Program. ASIST teaches you how to identify risk, how to apply interventions, how to come to agreements to keep people safe and so it's a combination of those two programs that we provide to deal with suicide or risk of suicide.

Q. And you mentioned the ASIST training is an internationally recognized thing, it's not a VAC thing.

A. No, it's not a VAC thing. We purchase ASIST. But ... and, often, when we recruit people, say, from provincial entities, they've already had ASIST training because other organizations who work in the same type of work that we work in use the ASIST training program.

Q. Once a case manager comes on staff, what sort of caseload are they assigned?

A. So when someone comes on staff, we work through their engagement in the NOTP program. That's the national orientation and training plan. But it tends to be incremental assignment of caseload. So we get people in through the door. We get their systems up and running. We teach them how to interface with our programs, et cetera, and then we start layering on program and

policy information and things like the mental health and ASIST.

And so, typically, cases are assigned incrementally. Once it's deemed that someone is ready to start taking on cases, the veteran service team manager may assign them ten cases to begin with and then as they familiarize themselves and make contact with those veterans, we'll add cases basically as time goes on.

Q. And so what's a manageable number for someone who's, you know, fully trained and really into it?

A. So it's very difficult to articulate a number because our cases are very different in terms of the amount of effort they require. Some veterans require daily intervention. Others who, say, are further progressed along in their rehab plan may really only require a check-in once every three months. So there is no perfect number. I can tell you that many case managers have said to me 30 to 35 is a manageable caseload. The Department has had a goal of 25 to 1 for some time. It really is a combination of the intensity of the cases as well as the competency of the case manager particularly what a reasonable caseload is.

Q. And over the years, I think it's no secret that resources have fluctuated and various governments have had input into that. What's the case manager's situation now? Do you

have more case managers on staff than you used to or what's the workload situation?

A. We've done massive recruitment in case managers. I can speak directly to my area, Newfoundland and Labrador and New Brunswick. As an example, in 2014 we had 17 case managers on staff in New Brunswick. Today, we have 41 case managers assigned to the New Brunswick area. So we've done massive recruitment.

But it's important to note that our case management numbers have also climbed over that period of time. So somewheres around 2015 we were around 8600 case-managed clients. We're over 15,000 today. I believe the last number I read was 15,150 clients in case management. So we have bolstered our case management resources significantly but our case management numbers have also risen dramatically.

Q. So when someone is assigned a case manager is it for a limited time or how does that work?

A. So VAC really has a continuum of care and so the idea is VAC will always be there but the level of intervention you require may change over time based on your personal circumstances. So case management is typically for a limited period of time. It's intense intervention with very specific

goals. Once those goals have been achieved an individual will move out of case management and potentially move to guided support or complete independence.

And then, over time, if their situation changes or their barriers come back and they are unable to cope, they can come back into the case management model. So it's an ongoing process of in and out. But nobody is, let's say, You're done with VAC. Anyone can call at any point in time and say, I need more help. And then we'll assess what level of intervention they require and if we require to refer them back to case management, we do.

Q. So when someone has a case manager, they could be in the care of an OSI clinic or they could be using community services. Is that correct, either/or?

A. Yes, that is correct. So I would say the vast majority of our clients are using community resources, fee-for-service resources, private psychologists, psychiatry, that charge us on a fee-for-service and we have good working relationships with. But we also use the OSI clinic. Especially in complicated situations or situations where we're not able to find a local provider with the expertise required, we will use the OSI clinic services. And, of course, the OSI clinics are very specialized because they focus on still-serving and

veterans with operational stress injuries and so they have a high level of competency in the area.

But they can also provide support to providers in the community and, theoretically, a veteran could be seeing a private provider and we could refer them temporarily to the OSI clinic and then they could come back to a private provider, et cetera. It's not a one or the other. We try to develop a plan that works best for the veteran.

Q. And I think we heard from other witnesses that it's possible to do a telehealth situation with an OSI clinic. Is that right?

A. Yes. So our clinics are offering telehealth right now. So we can basically ... very much like this, a video conference. Veterans can be treated in rural areas, as an example, through the OSI clinics without the requirement for travel. Or we also have health-related travel, so we can pay for individuals to travel. And just as an example, as the director for Newfoundland and Labrador, I have many clients that live in rural parts of Newfoundland or Labrador who might travel to St. John's, as an example, to see their treatment providers and/or they can avail of telemental health and do that from wherever they live.

Q. Was that available before the COVID pandemic or is that a thing that's just arisen now?

A. No, that's been available for quite some time. Yeah. We've been experimenting with telemental health really in ... I can only speak from my experience. But I became the area director for Newfoundland in 2008 and we were using telemental health at that point in time.

Q. And I believe we know from previous evidence that the OSI clinic in Nova Scotia is in Dartmouth, in fact, in HRM. That's the only OSI clinic in Nova Scotia, is it?

A. To my knowledge, yes, it's the only OSI clinic in Nova Scotia.

Q. We didn't ... you mentioned earlier "area offices" and I didn't ask you ... where are the area offices in Nova Scotia located?

A. In Nova Scotia there's an area office in Halifax on Chebucto Road and then there's another office in Sydney, Nova Scotia.

Q. So what exactly do case managers do for a veteran and what do they not do?

A. So case managers don't make decisions for veterans. They don't provide direct treatment. They are advocates. They

assist them in problem solving. They assist them in identifying and articulating barriers and strategies to either alleviate or reduce those barriers. They do a lot of community referral. They rely on the assessments for professionals in the community and/or OSI clinics to treat the veteran, say, when it comes to psychiatric conditions or physical conditions, we would again rely on private providers.

(11:00)

The individual's GP is typically heavily involved. And depending on what the nature of their illness or injury is, of course community providers related to that. And they can be provincial providers or fee-for-service providers. But because VAC pays and pays quickly without issue and there are no wait lists, we tend to do a lot of private treatment versus relying on provincial resources.

Q. So does a case manager locate a caregiver and recommend that caregiver to a veteran or how does that work?

A. So veterans are encouraged to make their own decisions. Ideally, what should happen is we will advise a veteran to identify somebody in the community who can provide that service, you know, just like you would look up a lawyer, you would look up who the psychologists are, you would verify

that psychologist is registered with Medavie Blue Cross. We can, in certain circumstances, provide a list of registered providers that we're aware of and share that with the veteran and then the veteran can make their own decision. And if a veteran is having difficulty making a decision or doesn't know who to provide, sometimes we will say, Well, talk to your colleagues, get recommendations or we might say, you know, we might say, Well, these two psychologists are known for providing services to veterans in your community maybe you want to call one of them.

So it's very important for the veteran to make their choice as much as possible and we just provide the level of intervention required for that veteran to make that choice, if that makes sense.

Q. And if the veteran identified a service provider, would the case manager make appointments and do things like that?

A. No, not typically. Again, the idea is to foster independence and to encourage the veteran to engage in the case plan. What a case manager may do is, in the case plan, may articulate and agree with the veteran that, You are going to call the psychologist and make an appointment within the next

two weeks, and after that appointment is made, you will call me to verify the appointment is made. And the idea there is you're providing structure and specific targets so that the veteran will follow through on that plan and call the provider themselves.

Q. And what could a case manager do if the veteran didn't follow through?

A. Well, you know, you would continue to encourage the veteran to do it. If you have the permission of the veteran, you may reach out to the psychologist and, you know, advise them that you have somebody who is looking for treatment but, ideally, what you want is for the veteran or the veteran's support network to reach out and obtain services because that's what we're trying to teach, that's what we're trying to encourage, strategies for getting support in the future.

Q. So if a particular veteran is having a lot of difficulty even making an appointment, the case manager might go ahead and do that for him?

A. Potentially they could. The other option is the clinical care manager. So, if I may, a clinical care manager is a specialized service that we engage in, say, less than ten percent of our case-managed clients, okay? But a clinical care

manager is typically identified, say, when a veteran is having difficulty just achieving the action items in their case plan. It can be if somebody has poor coping skills or problem-solving skills. If somebody were very acutely ill with multiple conditions, all exasperating their situation, and they were unable to action basic things like calling a service provider on their own, we may engage the services of a clinical care manager, and a clinical care manager is really intended to work more closely with a veteran to coach them for those types of things, walk them through how to do it, to encourage them how to do it, et cetera.

Q. So let's talk about clinical care managers then. How would you get one of those?

A. So the clinical care managers fall under our program of choice 12, so it has to be an approved benefit through the case manager, typically. The service can be identified in multiple ways. A case manager may, in their interactions with a veteran, if they're unsuccessful, identify that a clinical care manager would be an appropriate resource. They talk to the veteran: Is this something you'd be willing to avail of? If the veteran agrees, they'll usually consult with subject matter experts in our organization, whether it's a mental health

officer, case management practice consultant, or the interdisciplinary team, to get their feedback on whether this is an appropriate intervention. If all hands agree, then the case manager will then engage the services of a CCM, or clinical care manager, to work directly with the veteran.

Sometimes, private providers or an OSI clinic will also recommend a CCM. So providers in the community that work with our veterans regularly and know how we work will sometimes identify, this veteran could benefit greatly from a clinical care manager, and they'll make that part of their recommendations and share that with the case manager, and then the case manager would follow those same steps, engage with the veteran: Is this something you're interested in doing? And then go through the process of approving it.

Once it's approved, if the clinical care manager is already registered with Medavie Blue Cross and has access to our electronic system to work with VAC, which is called "BHSOL" or "Benefit Health Services On-Line", they will engage the client and then continue to engage VAC by submitting supports through that system through the case manager.

Q. Okay, that was a lot of stuff. So I just want to return to a few things. The case ... so if there's a suggestion

that a veteran would benefit from a clinical care manager, and you mentioned there's like consultation that goes on, who actually approves the veteran for that service? Can the case manager do that?

A. The case manager.

Q. And you talked a bit about what clinical care managers do. They don't give treatment. They're there to give ...

A. No.

Q. ... a higher level of assistance with day-to-day things?

A. Right. So it's specific to the needs of the veteran and what's established with, say, the health care provider, like a psychologist, and the case manager, but they will do things like provide education around the individual's particular condition and how it impacts their interactions in daily life. They may do motivational interviewing techniques or coaching to help a veteran, say, make that appointment and walk him through and encourage him as to how to do that. They will also do things, for example, if there is a particular exercise or activity that a psychologist wants the veteran to engage in, the clinical care manager can work with the client to practice those techniques.

Q. What are the qualifications of a clinical care manager?

A. So clinical care managers are either social workers, occupational therapists, psychologists, or nurses, and, in Quebec, they also engage psychoeducators. The provider has to be registered with their regulatory body and then registered with Medavie Blue Cross, be in good standing, of course, with the regulatory body, and have up to five years' experience in their profession.

Q. So when you or when VAC engages a clinical care manager who might be a social worker, say, you're not engaging them to do social work services, you're specifically engaging ...

A. No.

Q. ... them as a clinical care manager. That's correct, right?

A. That is correct. They are not providing treatment.

Q. So is the term "clinical care manager", is that a designation that's recognized or is that just what you call these people who are engaged to do this job?

A. As far as I know, it's a name that VAC created to fill this niche, so it's a VAC ... not position, it's a VAC

description versus some sort of domain, yeah.

(11:10)

Q. And how long, typically, would a clinical care manager be engaged to work with a veteran?

A. So it's very specific to the needs of the individual and what the goals are, but we have clinical care managers engaged for periods of three months up to two years. The intent is that it's a short-term intervention because we are trying to facilitate independence, not dependence, so it needs to be very specific and targeted, and once the goals that are set between the clinical care manager, the client, and the case manager are achieved, they should be disengaged, but we typically initially approve for 90 sessions, which is 45 hours, and it's not uncommon to extend the service if it's required to extend it.

Q. Okay, but assuming that you could have a case manager potentially for years. Is that right? A case manager.

A. Sorry, can you re- ...

Q. You could ...

A. You could have a case manager for years.

Q. But a clinical care manager, if you had one for a year, would that be out of the ordinary?

A. It would typically be out of the ordinary because it's

intended to be a very specific short-term intervention. So if you are extending a clinical care manager, say, beyond a short-term period such as three, six months, if you get up to a year, we, as in VAC, the veteran service team manager, and the subject matter experts, would be encouraging the case manager to have discussions with the subject matter experts to determine: Is this the best resource? Is it achieving what we expected to achieve? Are there other resources or actions that we could do to improve the situation? Because, fundamentally - I'll bring it down - what we're trying to do is foster independence to teach individual skills to manage the symptoms or barriers of their physical or mental health condition and if, after a year, that hasn't happened, then we may need to change our strategy. That is not to say that we would turn off the clinical care manager instantaneously, but we may strategize as to what other types of interventions could we engage here to get the veteran to where we need that veteran to be.

Q. How many clinical care managers are out there? Are they numerous? What does a person have to do to connect with VAC as a potential clinical care manager?

A. Right. So Medavie Blue Cross basically manages our POC 12 and they advertise clinical care managers on their

external website. So when providers engage with Medavie Blue Cross, they will self-identify as clinical care managers, and assuming they meet the requirements, can register as clinical care managers. And my understanding is the majority of our clinical care managers self-identify in that way.

We do have a mechanism - "we" being VAC - where, if we feel there is a particular area where there's a shortage of clinical care managers, we can engage Medavie to do outward recruitment for the clinical care manager position, but it's important to note that we are not engaging all of the clinical care resources that we currently have registered. In other words, we're only using a portion of the clinical care managers that are currently registered with VAC because it's a very specialized resource used in very specific situations and, as I said, in my former area, Newfoundland and Labrador, New Brunswick, and PEI, we're using ... we probably use clinical care managers more than average. We have over 2,000 case-managed clients and we're using about 170 clinical care managers, so that represents a very small portion of the case-managed clients that we have.

Q. Are you able to comment on the availability of clinical care managers in Nova Scotia in 2016?

A. I'm, you know, I'm not in the sense that I knew what

was happening with clinical care managers in Nova Scotia at the time. What I do know about clinical care managers is that in urban centres, we tend to have plenty of them, but in rural communities where there are less community-based social workers, psychologists, nurses, and occupational therapists, we have fewer clinical care managers because a need hasn't been identified previously.

Q. Okay. And you mentioned ... so we understand that clinical care managers are nurses, social workers, or occupational therapists, but you mentioned the Benefits Health Services On-Line. Can you tell us a bit more about that and what it is?

A. Right. So Benefits Health Services On-Line, or BHSOL, the abbreviation, is our digital platform that allows us to engage and receive reports from external providers. So what happens is the clinical care manager can submit monthly reports via the BHSOL system and they are electronically available then for the case manager to review and then saved onto our client service delivery network. So, obviously, external providers can't access our client service delivery network, so BHSOL is that digital platform that allows them to provide us digital information that can be attached to our, basically, our client

records.

Q. And what's involved? So assuming a person who is identified with Medavie as a potential clinical care manager has to somehow be trained with BHSOL, how does that work?

A. So once they're identified and registered, then we have to get them an account, and then once they have an account, they are identified for training. Training is not instantaneous. There's a group in Charlottetown responsible for the training on BHSOL and they will organize and schedule the training based on the number of providers they have in a particular area, and they try to rotate that training, obviously, around the country, but one has to attend the training before they can engage in the BHSOL system.

Q. And how long does the training take?

A. I don't know exactly. It's within a week. I believe it's like two days of training but I'm not a hundred percent certain as to the length of time.

Q. Is the training done remotely or in person?

A. Historically, it has been done in person. I don't know, since COVID, if they're doing it remotely or not.

Q. Returning to case managers for a second, I forgot to ask you, would they normally be doing things like driving a

client to the airport and things like that?

A. Not typically. That would be, you know, at a level higher than we would expect somebody to engage to drive somebody to an airport, yeah. It can happen but it's not something that's necessarily encouraged.

Q. You mentioned, when you were talking about the consultation on clinical care managers, you mentioned a mental health officer. Can you tell us what that is?

A. So a mental health officer is one of a variety of subject matter experts that VAC has on staff to help support the Department, particularly our frontline services, in this case, to strategize around their cases to help them resolve or develop recommendations or make decisions on occasion about particular benefits.

Mental health officers, there's a handful of them in our organization, and they tend to have subject matter experts in the area of mental health, obviously, at a Masters level, and, you know, experience or a background that would give them insight that maybe a typical case manager may not have in a complicated mental health file.

Q. You mentioned earlier the relationship between Canadian Armed Forces and Veterans Affairs now, and that you

have a good relationship. There's a transition that happens when a veteran is releasing from the CAF and can you speak a little about how that transition is handled?

(11:20)

A. I'll speak mostly of VAC's role but, in doing that, I may have to touch on some aspects that CAF is involved in, obviously. So one of the first things that we tend to engage in with veterans is participation in SCAN seminars. SCAN seminars are led by DND and veterans ... sorry, still-serving members who are engaged in the releasing process will go through a SCAN seminar and VAC presents that, those seminars, and explains what our benefits and services are in general. Often, we'll stay around and ask questions, et cetera, or answer questions, et cetera, for folks after those SCAN seminars. So that's one way VAC engages sort of pre-release.

The second piece is VAC completes a transition interview, and a transition interview is a specific targeted interview that releasing veterans go through where VAC will help them identify what potential concerns or challenges or barriers might be to release. So we'll talk about transitioning to civilian life and things that you need to consider. We may identify risks at that juncture with the veteran. And, again, this is one of these

processes where we try to engage the family, so we always invite the veteran to include their family in these discussions. So we talk about risks, and then we'll talk about specific VAC programs that they may want to apply for, whether it's a disability program or rehabilitation. We also may talk about community resources or services at that point in time.

And then I guess the fourth goal would be we provide an overall picture of the services and benefits that VAC provides, again just to ensure that the veteran and, hopefully, their family, understand those benefits.

In 2015, we also would've done a specific targeted questionnaire called a "RRIT" or a "RRIT-R", Regina Risk Indicator Tool, and we would've gathered information based on the veteran's responses that would've potentially identified a risk to transition to civilian life at that point in time.

And so that is, that transition interview occurs before the veteran's release. Today, we try to have that interview earlier. We've aligned our tools with the CAF so the questions we're asking and the topics we're talking about are similar to conversations that the CAF is having with these members before they even get to VAC and, depending on the veteran and when they're releasing, should have it at least, you know, a month

before release, so if there's anything that they need to resolve while they're still serving, they can. And, yeah, so that's the transition process and it's a continually evolving mechanism.

We don't do the RRIT-R anymore, but we still continue to do transition interviews with CAF members. We just have new tools that we're utilizing.

EXHIBIT P-000278 - TRANSITION INTERVIEW

Q. I just want to refer to Exhibit 278. Can you see that document, Mr. Marshall?

A. It's there. It's very small, but I can see it.

Q. Here you go.

A. There you go, yeah.

Q. Okay, so is this the transition interview you were talking about and do you recognize this sort of document?

A. This appears to be the transition interview tool, yeah.

Q. And I just want to flip to the second to last page. I'm not sure there's a page number to the ... that's it. And so that's the Regina Risk Indicator Tool you were speaking of?

A. Yes, it is.

Q. And this one says the reason completed is transition interview for Lionel Desmond, and at the bottom, I see he is

rated a moderate risk. Can you see that?

A. I can't see the bottom yet, but ...

Q. Oh, sorry. And this says it was completed by Allison Christensen. Would that be a case manager or who would normally complete the risk indicator tool?

A. That would've been a client service agent at the time or a veteran service agent would've completed ... they complete the majority of our transition interviews.

Q. And it says the date completed is May 25th, 2015, so that's pre-release because we know he released in June. So does that make sense to you?

A. Yeah, it should be completed prior to release, and if I'm reading it, it was about a month before the release date, if the release date is June 26. So that's an appropriate time for the transition interview to occur in 2015.

Q. Are you able to comment at all, and you may not be, but what's a moderate risk represent? Like how many releasing members would be assessed with a moderate risk and is it unusual or not?

A. So I don't have statistics on what the average risk ratings were. I think it's important to explain that the Regina Risk Indicator Tool, especially the "R" ... and "R" stands for

"re-establishment" ... the Regina Risk Indicator Tool was a tool developed by the Regina health authorities initially for elder people and it assessed their risk of need for placement, but VAC worked with the Regina health authorities to develop two versions of the tool. Just the Regina Risk Indicator Tool which helped us assess risk of placement for, say, elder veterans, but then we established this version which is Regina Risk Indicator Tool for Re-establishment, and what it is doing is, at this point in time, based on the responses of the individual, it generates an objective score which creates that risk level. So a moderate risk would've indicated that it would've been forwarded to a case manager for review and a decision around whether case management services were required, whereas if you get to at risk or high risk case management services would be indicated just by the score itself. But, keep in mind, it's a point in time, so based on the individual's responses at that point in time, he would've gotten a score of 14, so that should've resulted in the veteran service agent sending a work item to the office for a case manager review of this, the transition interview, and information and potentially a follow-up assessment.

Q. Okay. So, obviously, when you're in uniform with

Canadian Armed Forces, they will tell you what to do. Not necessarily so when you release and you're a veteran. And so that's where ... if you get a case manager, you talked about the fact that you would make a plan with your case manager. I wonder if you could talk about health records a bit? So what we know is that when you're in the Armed Forces, they take care of your medical benefits. What happens when you're releasing from the Forces in terms of health records?

A. So I could tell you, today, my staff are typically recommending veterans request a copy of their service records before they release so that they have access to them, and that's really to ensure that if the veteran requires that information for application down the road, that they have easy access to it and they can present that information, but VAC is also working really closely with CAF to expedite our access to service health care records, specifically for the purposes of rendering decisions around compensation for what was formerly called "disability award". Today we call it "pain and suffering compensation". And so while that's something that I would, recommend to a veteran, say he should attempt to get access to that report, VAC can also access that on behalf of the veteran when they're making application for compensation.

(11:30)

Q. So we talked about the fact that VAC is not a keeper of health records but a veteran can obtain their health records for their own use and future assistance. That's right?

A. That is my understanding. I can't speak on behalf of DND but I do know that it is not uncommon for veterans to request their records and to have those records.

Q. And was that any different, do you know, in 2015?

A. I do not know.

Q. Okay.

Your Honour, I thought I could finish before the break but perhaps it's time for a break. I'm almost done.

THE COURT: All right. Well, let's take a short break.

Mr. Marshall, we typically break around this time in the morning to give everyone an opportunity to stretch and refresh, so-to-speak, so if you don't mind, we'll adjourn for maybe 15 minutes or thereabouts. You can leave the connection established that we have so you can walk away from your computer if you like, and appreciate that if you turn the sound down or mute yourself and then return maybe in 15 minutes or thereabouts.

A. Okay, will do. Thank you.

THE COURT: All right, thank you then, Counsel. We'll recess for approximately 15 minutes, thank you.

COURT RECESSED (11:31 HRS)

COURT RESUMED (11:51 HRS)

THE COURT: Thank you. Ms. Ward?

MS. WARD: Thank you, Your Honour.

You talked about the CSDN, Client Service Delivery Network, and I just want to talk about that for a second. That's an electronic system. Who can access the CSDN?

A. So CSDN is restricted to employees of Veterans Affairs. I do believe there are some exceptions to that, such as the ombudsman and maybe some Royal Canadian Legion folks who input or assist veterans with claims for disability, but, other than that, it is restricted to employees of Veterans Affairs and, depending on your position, levels of access are based on your position, whether it be case manager, veteran service agent, veteran servicing manager, et cetera.

Q. And does the CSDN document every client interaction with a veteran?

A. More or less. It's our main area to document client interaction so, certainly, anything substantial would be documented in CSDN, yes. Any screenings, transition interview

assessments and, in 2015, case plans are also in the CSDN.

Q. Where are the case plans now?

A. Last year, a new tool was implemented called "GC Case", part of our initiative to improve our case management capacity, so it is a revised version, a separate tool from CSDN where case plans and case management monitoring and follow-up are housed but, in 2015, it all would've been in the CSDN.

Q. What if a particular veteran were to call their case manager several times in a day? Would each contact have entry in CSDN?

A. It's a matter of best practice. Often, what would occur is if someone received multiple calls, they may do a summary of the multiple calls as one client note versus separate entries, and that also helps ensure that, you know, the pertinent information is contained in one note versus spread out over three or four notes. So, as an example, I may receive a call from a client that prompts me to call their psychologist or service provider and then call the client back. So that entire interaction may be communicated in one client note versus multiple entries.

Q. And can you go back into the system and revise things later or change any entries?

A. Not once you've completed something. So if you input a client note and it's there, you can't come back and change it.

I should also add in documentation that it is normal for our folks to be engaged directly with veterans, whether on the phone or in person, travelling to homes, interviewing in homes, et cetera, through the course of their interactions. So the data entry into CSDN can occur at a later date. We try to get it in as soon as possible, but if you're busy serving the client and trying to help a veteran, the documentation may come a little bit later.

Q. I want to just touch on some of the other mental health services that may be available through VAC that we haven't ... We talked about the Veterans Affairs Canada assistance service. That's the 800-number for emergencies or urgent counselling you talked about, right?

A. That's right, yeah.

Q. And we know about operational stress injury clinics. Can you tell us a bit about Operational Stress Injury Social Support program?

A. Sure. So we refer to them as "OSIS". It's a peer support program. Members of OSIS are veterans who suffer with an OSI, or have an OSI, an operational stress injury, so

anxiety, post-traumatic stress, et cetera, and they receive training to basically provide peer support to veterans and/or still-serving members. They basically are open to anyone in the community, any veterans or still-serving members in the community who require their services.

Q. And what's the operational stress injury resource for caregivers?

A. That's an online tool that was developed to help support caregivers or family members for folks with operational stress injury, so that's available online to anyone who wants to avail of it.

Q. So spouses or family members can use that online tool?

A. Yes.

Q. And what exactly does it ... does it impart information or direct them to services or what is it exactly?

A. So it's really about facilitating understanding. VAC and, really, the Canadian Armed Forces, has put a lot of effort into supporting caregivers and supporting the network to, you know, encourage folks to talk about mental health, to help understand the impact of mental health on daily functioning, all in an effort to support the network of support for veterans or folks who ... still-serving members who suffer with operational

stress injuries.

Q. And what's a "veteran family program"?

A. The veteran family program is really the MFRCs ... oh, excuse me here, members' family ... I can't, off the top of my head, tell you. I'll tell you now in a second what "MFRC" stands for.

Q. Military ... is it ...

A. But they're the resource ...

Q. Is it ...

A. Military and Family Resource Centres.

Q. There you go.

A. Yes. Sorry. So it's access to the Military and Family Resource Centres for veterans. Historically, MFRCs have been available for serving members. VAC has an agreement now to provide access for veterans to the MFRCs so, depending on your location, MFRCs provide an array of services, from childcare, I know people who've accessed family support social workers there. They can provide things like ... I know people have been recruited through, for positions through MFRC, so it's an array of support services, kind of grassroots based, that was historically only for Canadian Forces members, but now is available for all veterans.

(12:00)

Q. And what's "mental health first aid for the veteran community"?

A. Mental health first aid is a program, it's an education program designed to basically dispel some of the myths of mental health, to break down stigma, to encourage folks to talk about their mental well-being, stress, anxiety, those types of things. It provides sort of an overview of, you know, mental health conditions and mental health stressors, and then some techniques and concepts about how to talk about it and how to gain support for mental health pressures or disorders or conditions, and it was specifically revamped for military life, so, often, out of the MFRCs, they will run the mental health first aid for caregivers and veterans in the community all in an effort to, again, you know, encourage people to talk, to help understand what's required for support in the impact of mental health, and, again, to reduce stigmatism and provide a network of support for veterans in the community.

Q. And, finally, Veterans Affairs has some bereavement services for grieving people. Can you just touch on that a bit?

A. It's through the 1-800 VAC assist line, so we can refer bereaving families to the 1-800 VAC assist and they

provide up to 20 sessions of bereavement counselling through that service.

Q. When Veterans Affairs Canada learns of a veteran's suicide is there any process or anything that takes place within Veterans Affairs in response to a veteran's suicide?

A. So two things. There's a process to ensure we identify who the next of kin is, who is going to contact the next of kin, who is going to counsel on benefits and services and condolence letters. And, secondly, there's an informal review, a summary, if you will, of the situation of the veteran, any services and benefits they might have been getting, et cetera, and that information is shared with the Director of Strategic Operations, I believe is the title, in VAC, as well as the DG and some other senior management so they have an opportunity to review the situation.

Q. Were you involved in any such informal review in Mr. Desmond's case?

A. No, I wasn't, although the document was shared by counsel after the fact just recently.

Q. And is that a statutorily-mandated process, do you know?

A. No, it's not. No, not to my knowledge. It's just an

informal process that VAC endeavours whenever we have an unfortunate suicide.

Q. And what's the goal of that review?

A. First and foremost, it's to ensure we understand the context of the situation to identify who the next of kin are, et cetera. It will also look for any glaring errors or concerns as a result of that file review.

Q. And, to your knowledge, if any concerns are raised, would they be addressed in policy or otherwise?

A. Depending on the nature of the concern, yes. It may be flagged for a policy, or a project, or a change in business process.

Q. Thank you, Mr. Marshall. Those are my questions for you. There will be some other questions from other lawyers.

A. Sorry. Sorry.

Q. Sorry. Those are my questions, Mr. Marshall. I'm finished and there will be some other lawyers who will have some questions for you.

A. Okay, thank you.

THE COURT: Mr. Russell? Mr. Murray? Would you like to go now?

MR. MURRAY: Yes, Your Honour.

THE COURT: Thank you.

CROSS-EXAMINATION BY MR. MURRAY

(12:04)

MR. MURRAY: Thank you. Mr. Marshall, I just have some questions to help us understand and just clarify some of the things that you've told us today, so if you could ... can you hear me okay, first of all?

A. I can. I can hear you great, thanks.

Q. Okay. So I may ask a couple of things that you've already explained, so just bear with us here.

So you said that there are, essentially, three types of benefits that veterans can get. One is the compensation for injury ... or pain and suffering, I guess, which used to be called the "disability award". The second is the income replacement benefit and the third is the reimbursement for medical services or medical aid, I guess. Would that be a way of referring to it?

A. So in the context of this file, the benefits that I reviewed, those would describe the three types of services, but there are a vast array of other benefits and services VAC provides that, you know, I would need a day to cover, at a

minimum, with you folks. But, yes, it's correct to say, compensation for injury or illness, financial compensation while somebody is participating in the rehab program, and then, in this particular case, there is reimbursement for health services rendered which is arrayed from, you know, medical devices to medications and health care providers.

Q. All right. And the disability award ... and Lionel Desmond, we see from the summary that was prepared, did receive an award for disability. You said two things about that. One, when you're assessing that disability, the first, as I understood it, is how much of it is attributable to a veteran's service with the Canadian Armed Forces, and that's rated on a scale of one to five?

A. Yeah, that's right, yeah.

Q. So if I, for example, had ... and pardon my example, but it's one that I think of. If I had a back injury that I sustained while I was serving in the Canadian Armed Forces, and my back was perfect before that, that might be a five out of five, for example.

A. In all likelihood, yes.

Q. Okay. Conversely, if I had a lot of back problems pre-existing and then exacerbated them while I was serving, that

might be a two out of five or a one out of five. Do I understand that correctly?

A. Yes.

Q. Okay. And then the percentage of disability, so a hundred percent or 50 percent, do I understand that that's how much that you are actually disabled from being able to, what, be employed or just carry out the normal functions of daily life?

A. Yeah. I'll be careful here now because this is beyond the extent of my expertise. I've never been an adjudicator and I've never attributed a percentage to an individual, but I think how I would describe it is it's the extent of the injury or illness, and the impact of that injury and illness, on a scale ... So, for example, if my back was such that I could no longer walk, I couldn't bend over, I couldn't look after myself, then that would be a higher impact then, say, if I just had a, you know, chronic pain, but I was still able to function and go about my business day to day and, you know, in layman's terms, that's how I would describe it.

Q. Okay. So, again, and your example, if I, for example, I couldn't walk, I might be approaching close to a hundred percent. Conversely, if, as you say, I had some chronic pain, I might be a 50, or a 40, or a 60, or what have you.

A. Right. And it's also important to note that these percentages are often accumulated because now, more than ever, many of our veterans have multiple conditions for which they are compensated for. So you could be assessed at a hundred percent and that may be an accumulation of impairments, illnesses, or injuries.

(12:10)

Q. Right. Okay. All right. And the, what we now call the "income replacement benefit" ... I think I have that correct.

A. Right.

Q. A veteran will get ...

A. You do.

Q. A veteran will get that if they are engaging in rehab services with a goal to becoming gainfully employed again and fully functional? Is that basically the idea?

A. Yes. And I don't have the legislation in front of me, but I believe the terminology is applied or engaged in, so it is possible for somebody to apply for rehabilitation and move right into diminished earnings capacity. In other words, it's deemed that they will no longer be capable, sort of re-engaged in gainful employment, and so they could move right into IRB to the

age of 65, potentially, although, of course, the goal is always to rehabilitate them. Even if, from an employment point of view, we can't rehabilitate them, we may still focus on mental or physical rehabilitation and for the purposes of, you know, function and reintegration to society socially.

Q. And if a veteran is receiving compensation for, or monthly payment through, the SISIP insurance program, which is, I understand, from the Canadian Armed Forces, if that's more than they would receive in the income replacement benefit, they only get the SISIP. Is that correct?

A. Well, it's not the case anymore. So in the fall of 2016 - I don't know the exact month - VAC made a decision to start paying at 90 percent of the income of the veteran. So, today, if you were on SISIP, you would still apply for IRB because SISIP would pay you at 75 percent of your income, whereas IRB would pay you at 90 percent, so we'll top off your SISIP payment up to the 90 percent level.

Q. Right.

A. That came into force, as I said, in the fall of 2016. When a veteran applies for the rehab program, they have to apply separately for the income replacement benefit. We typically encourage people to apply, particularly now, at the 90 percent

level but, in 2015, it is possible that somebody would choose not to apply for ELB because they would've been aware that they wouldn't have gotten any additional money from earnings loss because they were getting a SISIP top-up. Then, in September/October of 2016, when we did the 90 percent top-up, veterans would then apply for the 90-percent top-up so they could, at that point in time, apply for ELB.

Q. Do you know how long the SISIP benefit typically runs? Is it time limited?

A. My understanding, yeah, as it's not my program and I'm not an expert, I would say my understanding is approximately two years but, you know, I don't want to say that with certainty.

Q. And, finally, for our purposes today, we talked about medical aid or health services, so things like pharmaceuticals or counselling that may be paid for by VAC or through Medavie Blue Cross. Is that correct?

A. Right. So, yeah, typically, VAC approves and Medavie Blue Cross pays or reimburses. When it comes to POC 10, which is medications, Medavie sort of ... not sort of, has the authority to pay without the need for approval because there's standard expectations on what we would approve for benefits. So Medavie has a set of rules they follow and they approve the

benefits on application. They don't come to the VAC or the case manager for a decision, typically.

Q. And if it's ... and so the ... I'll ask you this. The programs of choice that you refer to, of which there are 14, those are the various health services or medical aids that a person can access? They're categorized in 14 categories, are they?

A. Yes. So they are 14 of the health services that I referred to that are on the Medavie Blue Cross card. There are other benefits that VAC provides, like Veterans Independence Program, that aren't necessarily a part of that program, but if one made application, we would have other funding mechanisms for those.

Q. Okay. And there are probably, for example, in the category of pharmaceuticals, there may be a wide range of drugs that are covered by the Blue Cross program? And there's a list, I take it, is there?

A. Yes, there's some sort of list that they follow, and if there's exceptions to that list, then it is forwarded to the special authorization unit for review and decision and, typically, consultation with the prescribing physician.

Q. And the special authorization unit if, for example,

I'm a veteran and my doctor wants me ... and you used the example of a drug that maybe is newer, may have better efficacy than the one that's on the list, the doctor advocates for that. It's the special authorization unit, is it, that will ultimately say "yay" or "nay" to that?

A. Yes.

Q. Who makes up the special authorization unit?

A. It's a unit in Medavie. I can't tell you exactly who it is or who they are. I just know it's one of the functions that Medavie is contracted to ... one of the services Medavie is contracted to provide.

Q. So that's a Medavie unit, not a VAC unit.

A. That's right.

Q. Okay.

A. But we do have ... Sorry, just to clarify, we do have our own expertise around pharmaceuticals, a national ... I don't know if it's a national manager of pharmacy, but all of our programs have program managers, and so there are VAC individuals who are behind the scenes creating policy, writing formularies, or working with Medavie to develop formularies that Medavie uses to make decisions.

Q. Okay. All right.

A. And so, theoretically, Medavie could flag exceptions. For example: We have had multiple requests for this drug. Does VAC want to consider it into the formulary because it seems like physicians are using it more regularly now? So those conversations are ongoing behind the scenes. Not something that I've been a part of but I'm just aware that, you know, VAC manages that.

Q. Okay. And if the particular program of choice that we're talking about ... We've talked here about, I believe, the number of sessions that were authorized for Lionel Desmond with a clinical care manager, that was a hundred occurrences or a hundred sessions, and 16 with a counsellor, and those are typically half an hour, you said. It would be the case manager ...

A. So in clinical care managers, occurrences are 30-minute sessions. I am not a hundred percent sure for other health professionals.

Q. Okay.

A. But my guess is it would likely be the same, depending on the profession.

Q. Right. And if a person is case managed, it would be the case manager that would make the decision about how many

occurrences would be authorized?

A. So a veteran has the option to go directly, using their Medavie card. So if you have a disability award, you receive that Medavie Blue Cross card, and so you have entitlement to certain POCs, so you don't need, necessarily, a case manager to approve those benefits. You can walk into a pharmacy, you can walk into a social work office, and they will be able to direct bill without authorization from the case manager for almost all of those POCs. However, if one is engaged in the rehabilitation plan, the decisions around, say, health-related services like a clinical care manager, would then come to the case manager and ... Sorry, that's a bad example because a clinical care manager would require a case manager approval. But, for example, social work services or psych counselling, a veteran could access that outside of the rehab program the day he receives his Medavie Blue Cross card.

Q. Okay. And the number of sessions that you might get ... and I'm thinking more here about interaction with a person like a social worker, or a counsellor, or if it's a clinical care manager. The number of sessions that you would get, is that a standard number or is it decided by a case manager, if there is one, or how is that done?

A. So there are standard numbers of sessions or occurrences for each of the programs, but a veteran may access additional sessions, depending on their particular situation, through Medavie with the rationale of the health care provider and/or through case management services, you could potentially change that standard and increase the frequency and/or number of occurrences.

Q. Okay. So, for example, the hundred sessions that Lionel Desmond was authorized with his clinical care manager, would that be a standard number for sessions, or occurrences, I should say, with a clinical care manager?

(12:20)

A. Right. So my understanding for a clinical care manager is the standard maximum number is 90 occurrences. I'm not sure if it was a hundred back in 2015 or 2016 or not, but I know today it is typically ... and, just to be clear, it's the maximum number of sessions, but in my experience working with case managers is, more often than not, they will approve the full 90 because that allows the clinical care manager to continue working.

If you limit the number of sessions, of course, they need to go back and you need to preapprove, and so there's more

administration to that. So, typically, yes, 90 occurrences is what would be the standard approved amount.

Q. Okay. Now we had talked about the client service delivery network, and I take it that there's a wide variety of information that goes into that, and you said, until recently, the case plan was stored there, now it's stored somewhere else, but there's still a lot of information in that? Is that sort of the central hub for information relating to a veteran?

A. It is. It is our central hub for housing client information. Electronic - sorry - client information.

Q. And we talked about action items, either system-generated action items or action items that are put in by an employee of VAC. I'm just curious if, for example, someone at the call centre or a veteran service agent puts an action item into CSDN, is there a flag? I assume there's some flag that would come to the person to whom it's directed, like a case manager, or something that would prompt them to know that there's something there?

A. Yeah. So it works in two ways. If you work within that unit, I can assign a work item directly to you. And so it'll be attached to your CSDN sign-in. When you access CSDN, you can just basically click an icon and it'll list the work

items that have been assigned to you.

Conversely, if you work outside of that area; say, for example, an area office, so if you were in the NCCN and you wanted to send a work item to the area office, it will go into a generic queue and, normally, we have an admin person who goes through that queue and assigns work items accordingly, either based on geography or the nature of the work item. So they would have to go in and look at it and go, Okay, this work item is a notice of change of address and should go to the veteran's service agent. This work item is associated to Lee, the case manager, and I need to assign it directly to him. And so they do it that way. Typically, once or twice a day, that's done to ensure that they're assigned in a timely fashion.

EXHIBIT P-000273 - CAN002252 - MARCH 2021 REDACTIONS

Q. Okay. All right. So I'm just going to ask to pull up an exhibit, Exhibit 273, and this is a lengthy document, it's 22 pages. I'm just going to pull ... direct us to one page. Let's go to page 9, for example, and maybe zoom into the middle of this and just down a bit there. I'm assuming this is part of a document that would be printed off the CSDN system? Am I correct about that?

A. Yes, it appears to be ... so we have an area called

the "client note section".

Q. Right.

A. So we referred to this earlier. If you have an interaction with a client, you may document it in the client note section. And so this looks like a series of interactions that the case manager, Marie-Paule Doucette, had with the veteran and Exceptional Prepayment.

Q. So she would be entering these into this section of CSDN as she had those interactions or close in time to those interactions?

A. That is what it appears to be. I'm just sort of reading it as we go along, so, yeah, certainly, the first one, she's notifying of a change of address, making note of it, and preparation for a treatment discharge on August 23rd, 2016.

Q. Okay. And there's no magic about these, in particular. Just so I understand how they work. So this, the first one there, for example, would have been entered on August 15th, 2016, at 11:58, created by "MPDOUCE". That would be Marie-Paule Doucette, the case manager. Now she put an entry here: "Veteran's address had been changed in CSDN in preparation for treatment discharge, August 23rd, 2016. Seeing as he was approved for an earlier discharge, returning on

today's date, CM has activated the change of address effective August 15th, 2016."

So, again, he's coming back, it would appear, from Montreal, from his treatment there, coming back a bit early, so she activated a change of address earlier than was otherwise planned. Do I understand that correctly?

A. Yeah. So, if I understand it correctly, the change of address was likely inputted with a future date and because the veteran is returning earlier, she basically changed the effective date of the change of address. Now she would, in all likelihood, have changed the address physically on the system and is just making an additional note to clarify why she did that.

Q. Okay. So there would be a part of the system or a place in the system where the case manager, for example, could change the address of a veteran, and this is a note about doing it a bit earlier or something like that?

A. That's what it appears to me, based on what I'm reading, yeah.

Q. All right. Okay.

So a couple of other questions about things that we've talked about. You talked about ... and that's fine for that

exhibit, but you were directed to Exhibit 278, which is the transition interview, and I just wanted to ask a couple of questions about that so I understand. Who does the transition interview with the veteran? Who, typically, is assigned to do that?

A. In most cases, it's the veteran service agent or client service agent they were probably called back in 2015.

Q. Okay. And that's the, what did you call the VSA? It's the first contact queue or something?

A. Yes.

Q. What was it called? The ...

A. Well, they're the first line of contact in the area offices, so they are within the area offices, part of the veteran service team, work closely with case managers and the veteran service team manager and, in all likelihood, are assigned to a particular base, transition centre, and execute these transition interviews as part of their role.

Q. And the transition interviews follow a standardized format I assume, do they?

A. They do, yeah. So the document itself is more or less how the transition interview unfolds. Veteran service agents receive training as to how to conduct these interviews and,

certainly, they would've received training on how to conduct the Regina Risk Indicator Tool which is a part of, or was a part of, the transition interview in 2015.

Q. And all veterans or all members of CAF who are transitioning, I guess, or who are going to become veterans, go through a transition interview, do they?

A. All medically releasing go through a transition interview in 2015. It was ... my understanding is it was optional for non-medically releasing back in 2015, although we did offer transition interviews to them, but for a medically-releasing veteran, this would've been part of their release sign-off to have ensured that they conducted a transition interview with VAC.

Q. So for medically-releasing veterans, at least in 2015, they all went through this interview.

A. Or they should've.

Q. Right. Okay. And so you said the veteran services agent, they have training in how to conduct these interviews and the information that they're supposed to obtain?

A. Yes. And because they're standardized processes, you know, there's a flow of questions that have to be asked in a certain way, as well as the Regina Risk Indicator R Tool

standardized sort of way of asking those questions.

Q. Do you know how long the transition interviews typically take?

A. There's no standard time. It really depends on the individual. So somebody who has all their transition needs taken care of, there are no risks, can theoretically conduct an interview in 20 minutes, 30 minutes. That would be rare, in my experience. I've seen them go as long as two hours depending on the conversation and the flow of the conversation, and if a family member is participating or not, how many questions they have.

(12:30)

Q. Okay. And you said depending if a family member is participating.

A. Right.

Q. Is it standard for family members to participate in the transition interview?

A. It is standard for us to invite family members ... no, sorry, let me rephrase that. It is standard for us to encourage the veteran to invite family members. Whether they attend or not is really up to the veteran. I haven't conducted many transition interviews so I can't tell you what the number is but

it wouldn't be uncommon for veterans to go on their own without a family member.

Q. Okay. It's helpful then, it's perceived as helpful, I guess, or it's thought that it's helpful to have the family input and information from the family, though, when these interviews are conducted?

A. So it serves two functions. One, sometimes the family member has insight into situations or circumstances that perhaps the releasing member would not. And then, secondly, we also share a lot of information. We refer them to specific programs. We provide general overview of VAC programs. And, of course, it's always better to have a second person hear the same thing as you. So later on when you're trying to remember what you should apply for or how it works, you have somebody else who was there and can, you know, can help.

Q. Sure, okay. In looking at the transition interview, which we had marked as Exhibit 278, it would appear that Lionel Desmond's family was not involved in that? I mean you may not know that but there's sections here, for example, How does the spouse/partner/family feel about the member's pending release from the service?" And that's blank in his. That would be on page four. That may be because the family

didn't participate in the transition interview?

A. If it's blank, one could ... I didn't participate.

Q. Understood.

A. And I didn't review the file so I can't say with certainty. But if it's not filled out, that would indicate that nobody was there to answer the question. Or they refused to answer the question, I guess is the other option.

Q. Sure. No, understood. In Lionel Desmond's transition interview, we looked at his Regina Risk Indicator Tool R, and the one that was completed on May 25th, 2015 at page seven of the transition interview, and he scored a 14 out of 65, which was classified as a moderate risk. I wanted to ask you a couple of questions about that tool. And I appreciate that you say it's not used now but when it was used, could it be used multiple times or would it be administered at different times throughout VAC's interaction with a veteran?

A. Yes, absolutely. So it was to be used in the transition interview. It was also meant to be used, say, when the case manager did an assessment. An exception could be if the RRIT-R was done on a Tuesday and the veteran was assessed on a Wednesday, which is an unlikely scenario. But if there was a recent RRIT, you may not redo it. But, at different points

within the interactions, case managers, our nurses, or veteran service agents would have been required to re-answer those questions. And the idea is that it is one picture in time but it's a reference point that we can, you know, see progress or decline in a client situation based on RRIT scores as well.

Q. Okay, all right. So, for example, we saw 14 out of 65 on the RRIT that was done during the transition interview. It appears at Exhibit 277, there was another RRIT done on January 5th, 2016 and, on that occasion, Lionel Desmond scored a 22 out of 65, which would put him in the high risk category. So, again, the scores on RRITs, I take it, can fluctuate, can go up and down and, as you say, they're a reflection of a particular point in time.

EXHIBIT P-000277 - REGINA RISK INDICATOR "TOOL" - R

A. Right, and very much based on the responses of the veteran who is participating. And so it's a reflection of how they felt at that point in time or what their perception of their situation was at that point in time. So it is very normal for it to change over time.

Q. Okay, and it is based then or it was based when you were using it on self-reporting by the veteran?

A. Self-reporting to the specific targeted questions,

yes.

Q. Okay. Now you don't use that tool anymore?

A. No.

Q. So what tool has replaced it or how has it been replaced?

A. So VAC redesigned its screening tool and its transition interview based on what we refer to as the Domains of Wellness. And so our own research department has been working with Domains of Wellness for a number of years as a means to not only identify risk or success to transition but also how somebody is functioning at a certain point in time and their potential for success of functioning. So I want to say 2018 but I don't know with certainty, we revised the screening tool and the transition interview and now have our own standardized questions. Very similar in the sense of there are specific questions that they're based on self-reporting by the veteran and/or the veteran's family but we basically created our own tool based on research that our VAC research unit had done. That's been integrated into the, as I said, the transition interview and the screening tools as well.

Q. So the newer transition interview and the newer screening tool or the Domains of Wellness test or screening

test, who are those shared with when those are completed?

A. So they're very similar, I should say. They provide a score, just like the RRIT-R does. And so based on the score, that would indicate where the referral goes. So if it's a high score or a high risk, it's going to be referred to a case manager. So it would be shared with the case manager. It's possible if a veteran service agent does the screening down the road, they will refer back to an old screening and compare scores and say, Oh, you know, there's been a decline in this person's responses on the screening tool and the risk level has gone up. So they may use it as a point of reference. But it's basically used by the client service team or the veteran service team to see how veterans are doing, see how they're managing their issues, their risks, and whether those risks have gone up or down.

Q. So, again, if on the newer test if someone scored, and I don't know how they're broken down, but say they have a high score or a certain numeric score, they're automatically directed to a case manager, depending on the score. Do I understand that?

A. Yes. So we have a set of rules in the business process, how to interpret score, and what happens, what's next

to happen based on the score. But for the RRIT-R, anything from moderate risk up, tends to be a referral to the case manager for review. And, obviously, the higher the score, the higher the risk and, therefore, the higher the priority of reviewing that.

Q. And, I'm sorry, you may have answered this but the newer test, it's risk for what exactly?

A. So when it comes to the transition interview, it's really, it assesses the veteran's likelihood of success for transition. So if you score higher, then it's indicating that you have a higher risk of unsuccessful transition. So it's looking at things like whether you have a place to live, whether you have purpose, how your health is functioning. And so in responses to all of those variables, we get a good picture of, if this person has a plan, a safe place to land, employment worked out, a social network where they're going to arrive. I mean that's basically what we're describing but we're doing it in a very strategic pointed way based on research and responses to those questions. We get an indication of potentially what their risk is for successful or unsuccessful transition.

Q. Okay, so then it's a measure of the potential for success of transition or not.

A. Basically, yes.

LEE MARSHALL, Cross-Examination by Mr. Murray

Q. Okay. Does the new risk assessment tool and the new transition interview, does it assess suicide risk, specifically?

A. It's not a specific suicide assessment. So if, for example, in the questioning an individual identified risk to self or self-harm, then whoever is doing the assessment would move into our suicide protocol and start to ask the assessment questions about whether they have a plan, you know, and the details of that plan, whether they have a means to exact the plan, to assess suicide at that point in time. But, certainly, we do touch on, you know, all life areas and potential.

(12:40)

Q. Where the family may or may not be participating or the spouse may or may not be participating, is there any aspect of the test that measures the risk for domestic violence or problems in the home when the vet is transitioning back to his residence or her residence?

A. So are we talking the RRIT-R or the new tool?

Q. Well, I guess the new tool would be more relevant but either one?

A. So I mean it does touch on ... It doesn't assess for domestic violence? No. But it does touch on sport network and stability of the people you live with and your living

arrangement. So it would ask questions related to that, but there is no domestic violence assessment tool that we use specifically.

Q. Okay, all right. And do you know if the veteran service agents receive any training or if there's anything to sort of bring that to the front of their mind when they're conducting the interviews to determine if there's a risk for domestic violence or not?

A. So there's no ... Well, in 2015, there was no specific training around assessment for domestic violence. But, again, if you want to bring up the tool, you can look at the questions around living arrangements and how that piece will unfold. So there are indicators of what the family plan or the, you know, that part of their life is there. There's no specific training or there was no specific training, but currently VAC is, like other federal departments, is implementing **Bill C-65**, which is new legislation around harassment and violence in the workplace and one of the components to that is mandatory training for all staff and that certainly touches upon domestic violence. Not just for clients but in the workplace and it talks about indicators and actions and supports one might access. So we are getting there. There wasn't any specific training in 2015, to

my knowledge.

Q. You said that when a veteran is transitioning, they also get something, I think you called it a SCAN seminar?

A. Right.

Q. What's that?

A. So I'm out of my domain because it's ran by DND.

Q. Oh, okay.

A. But, basically, my explanation is it's a series of presentations about important things to transitioning veterans, things that they want to know. So, for example, SISIP may present there. VAC would present there. General presentations on what you need to know about our department and programs and services that you might be able to access post release.

Q. Fair enough. We talked about when a person or when a veteran will be assigned a case manager and, if I understood you, that it's most often when they are going through the rehab program or receiving or need rehab and the case manager will be the person who manages that.

A. Yes.

Q. But not all the time. There can be examples ...

A. No. So if you're on rehab, you'll have an assigned case manager.

Q. Right.

A. So ... and that's ... The difference would be, so if someone only has occasional needs and their income ... sorry, they may apply for rehab because they want the 90 percent top-up, but they're getting all the services and benefits they need from SISIP, ie. the VOC rehab. They may not access VAC services other than the 90 percent top-up, but at the end of the day, a case manager would potentially be assigned to them to approve the rehab program and to close it out when they were done.

Q. Okay, but if a veteran is accessing the rehab program through VAC, they're going to have a case manager, that's a definite.

A. They will, yeah.

Q. And there can be some veterans who are not going to be rehabbed because of their circumstances that may still need a case manager for something. Did I understand that correctly?

A. Yes, that is correct. Case management was around before the rehab program and the rehab program utilizes case management service and benefit coordination to help manage the rehabilitation program. So, legislatively, if you're on rehab, you need a case manager. But, if you're not on rehab but you have a complex need and require the services of a case manager,

you can still get case management. But, of course, are voluntary. It's up to he client to follow through and work with the case manager. While we may assign one, it's really a collaborative process. So if a veteran chooses not to participate in case management, they can do it. It's very much not like, say, Correctional Services where folks are mandated to participate in and listen to their parole officer.

Q. Right, okay. And you talked about the qualifications of a case manager and I don't know if I understood you. Have those changed at all, the basic requirements for case management or for case managers?

A. So they've evolved over the years. In 2015, we basically were recruiting people with post secondary professional degrees in health or social related. So social workers, nurses, occupational therapists, and some other exceptions. We've changed our criteria, what we call our Statement of Merit criteria, over the years because over the course of the number of years, we realize that there are case managers who exist who may not have, say, a social work degree but were recruited by Corrections and trained by Corrections and have been doing case management for five years. And so in efforts to ensure we are taking advantage of the full pool of

candidates in our communities, we have modified our statement of merit to ensure that if someone has a degree, say, in psychology but it's not a professional degree but they have experience in case management, we will allow them to apply for our positions and then evaluate them under case management skills.

Q. So I assume then that different case managers then bring different skills to the job. Does that impact how clients are assigned to case managers and, for example, if somebody comes from an OT background, they may be better suited for a particular veteran. A different case manager may come from a nursing background who may be better for a different veteran?

A. So, yes, that can happen. What we try to do is ensure that our case managers are more generalists. But, for example, if you had somebody with a really strong mental health background and you had a client with very complex mental health conditions, we may make an exception and assign that person based on that skill-set. VAC is also evolving in terms of within our own interdisciplinary team trying to engage our health professionals, for example. So we have nurses on staff who don't treat clients but they provide ... They do do nursing assessments and they do provide functional advice and guidance around nursing. So we're trying to engage them as an example in

the case management process where it might make sense for the nurse to take the lead on the case management file for a period of time because it's very nursing related. The case manager will always be primarily responsible for the case but we are doing things internally to make sure that we're maximizing the use of the resources we have internally.

Q. You said that your numbers of veterans who are case managed and the number of case managers have both increased in recent years. Did I understand that correctly?

A. Yes. Yes, that is correct.

Q. The change in, I guess, qualifications for case managers or broadening of that, was that a function of just needing to hire more people?

A. Well, the Treasury Board increased VAC's resources in 2014-2015 and we started massive recruiting. We had a goal of hiring 400 resources basically to support VAC in its endeavour of case management and other functions. And so I believe we went from somewhere around 270 case managers to somewhere around 470 case managers this year who are actively, you know, in positions and we continue to recruit. But, as I said, the number of case managed clients continues to rise and also the complexity of case management. So our clients today are

presenting with much more complex issues. We're dealing with folks with, you know, family issues, multiple health conditions, personality disorders. There are folks that have been a part of, you know, sexually marginalized populations. We are dealing with much more complex and, in some cases, often more ill veterans. And so not only are our numbers increasing but the complexity of the clients we're working with has raised.

(12:50)

Q. And do you have any sense of why that is, why you have both more case managed veterans and more complex issues?

A. I would say there's a couple of factors. VAC is doing a much better job of reaching people. When I first came to work with VAC, we really focussed on the veterans from the Korean War, World War I, and World War II. But in 2006 when we established the rehab program, we started to offer a suite of programs that was beneficial for the younger veteran. And so now we're involved with people who have young families, who are trying to find employment who, you know, came up through the ranks of CAF and have longer careers potentially. It wasn't the same group that went over and served in the war, released after the end of the war, and went back to civilian life. These are folks that have made careers out of CAF. So that's one of the

reasons we're just reaching more. Aside from that, I wouldn't venture to guess why it's more complex but I can tell you, it is much more complex work than it was when I started.

Q. And you also mentioned reaching marginalized communities. Is that an additional layer now maybe that wasn't as prominent before?

A. Or perhaps that wasn't ... these folks were marginalized and, therefore, maybe didn't self-identify as veterans or didn't come seeking services. But, yes, you know, over the course of the last number of years, we are breaking down barriers, we are breaking down stigma, and we are engaging in clients that perhaps previously wouldn't have come out to see us because they felt marginalized or maybe not supported by the federal government. It's positive steps. We're reaching and helping more people but, of course, it also presents with very complex cases.

Q. I mean we've talked a lot about post-traumatic stress disorder, in particular, in this Inquiry and we've heard that, you know, there may have been a resistance in the past for veterans to acknowledge that they may be suffering after they've left service. Do you see that changing and is that perhaps playing a role in the need for more services for veterans?

A. Yes, absolutely, that's been a major driver as well, the exceptions of talking about mental health and the exceptions of having a mental health condition, that has been made a major impact, of course, in terms of ... And we've seen that for a number of years, I guess, and so it's not at the forefront of my mind but we've made major steps in terms of comfort level of talking about mental health and talking about diagnosis and treating mental health conditions. I'm certain that's contributed as well.

Q. You supervise Newfoundland and New Brunswick, you said?

A. Newfoundland and Labrador, New Brunswick, and Prince Edward Island, although I am currently on assignment.

Q. Right. So, obviously, provinces that have larger geographic areas and some sparsely populated areas, people spread out a little bit, are there challenges with case management for people who are in rural areas and who are maybe some distance from urban centres?

A. There are. VAC has done a pretty good job of travelling to see clients in their homes. But, of course, that's not always possible. But we're making vast gains in terms of our ability to engage people via telephone. With

MyVACaccount now and the ability to have conversations online through secure messaging and, of course, things like telemental health, we are making improvements. But if you're in a small community with limited resources, we are still going to be presented with challenges in terms of securing the supports you require to meet your needs.

Q. You talked about business practices, I guess, and protocols. Is there any thought given to how close geographically a case manager has to be to their client? In other words, do you say, Look, you have to be within a hundred kilometers or ... I don't know.

A. We don't have a standard rule. We try to ensure that clients are managed by a case manager in the geographical area where, if they need to go out and visit them in the home, they can. But when we are trying to manage, say, in areas where we have difficulty recruiting, we may at times have more of a virtual relationship where, you know, there have been times where maybe somebody was case managed out of an office that wasn't necessarily next to their office. So, for example, in New Brunswick, we have an office in Oromocto and we have an office in Saint John. And it's not uncommon to have a client who lives in the Oromocto area to be managed by somebody in

Saint John simply because there are a lot of clients in the Oromocto area and we are trying to meet the needs of our clients with the resources we have in place.

Q. In terms of when a determination is made that a person, a veteran should be case managed, is there ... Can you tell us what kind of lag time there is between that decision being made and a case manager actually being assigned and being able to jump in and start doing something with the veteran?

A. Right. So there's no standard or average time I can give you. Certainly the risk or potential risk that a veteran presents with would be a driver when assigning cases. We try to assign him to a case manager as soon as possible and engage them in that whole conversation about rehabilitation and case management but there's no standard fixed time that we have in place that I can say all clients who are referred to case management are seen in this amount of time.

Q. And so when a ... I guess there's different routes to having a case manager and you say, ultimately, the veteran team services manager assigns the case manager. Is that typically how it happens?

A. Yes, it is.

Q. So like just so I have a sense now, and I know there's

a wide range of possible examples, but I mean it could be a couple of months perhaps before a person might get set up with their case manager? Could it happen quicker than that? Slower than that?

A. It could certainly happen quicker than that. If we have the resources and capacity in place, we like to place somebody, assign them to a case manager as soon as possible. So depending on location, depending on availability, depending on when the required assessments comes in, depending on when the veteran contacts us and engages, we could assign somebody certainly within a couple of weeks to a month. But when, 2015, we perhaps didn't have the resources in place in the Saint John office that we do now. We went from 17 in 2014 to 41, as you can imagine. So capacity can be an issue or availability.

Q. Right. And, as you said, the number of case managers has gone up dramatically over the last four or five years.

A. Yes. I didn't catch the first part of your question, I'm sorry, if you could repeat it.

Q. No, I think I just said, as you said, the number of case managers has gone up significantly over the last four or five years.

A. Yes, it has.

Q. Okay, all right.

MR. MURRAY: Your Honour, I don't know when you want to stop for lunch. I have a few more questions. I can keep going or we can stop now.

THE COURT: You have a few more questions. Is that five minutes or 15 minutes?

MR. MURRAY: I think it would be a little longer than that.

THE COURT: I think what we're going to do, Mr. Marshall, is we're going to take our lunch break. We normally break at 12:30 but I wanted to see how far we could get before we did break. We usually take an hour or thereabouts to allow for counsel to get a bite to eat. So can we come back at 2 o'clock? Where are you today, sir?

MR. MARSHALL: I'm in Newfoundland and Labrador. So 1:30, here.

THE COURT: It's 1:30 there, presently. All right, so we will come back in an hour to give you a chance to get a bite to eat.

MR. MARSHALL: Sure.

THE COURT: Thank you then. If we can just leave the connection up to your computer, Mr. Marshall, that will be fine

and we'll see you back in about an hour's time. All right, thank you very much.

MR. MARSHALL: Okay, thank you.

COURT RECESSED (12:59 hrs.)

COURT RESUMED (14:02 hrs.)

THE COURT: Thank you. Mr. Marshall, can you hear us all right?

All right. Thank you.

MR. MURRAY: I don't know if we can hear you.

THE COURT: Go ahead, Mr. Murray.

MR. MURRAY: Just want to make sure we can hear you, Mr. Marshall. Are we all clear?

A. Yeah. Sure.

Q. Oh, good. Okay.

A. All clear?

Q. Yeah.

THE COURT: Yes. Thank you.

MR. MURRAY: Just before the break, Mr. Marshall, I was asking you about case managers. And I just wanted to ask you, when a case manager is assigned, do I understand that one of the things that they do with the veteran is to create a case plan? Is that one of the first steps?

A. So not necessarily. If a client is assigned to a case manager, they may speak to the veteran. They may even do an ... or they should do an assessment of the veteran before they create a case plan.

Q. Okay.

A. So there's a process there. And it is possible that over the course of the conversations and the assessment, that they may determine that case management is not required and then refer back to the VSTM. So it's kind of later on in the process where the case plan is actually created.

Q. Okay. And so initially there's a meeting with the veteran. And does the case manager ... I believe I heard the case manager will actually meet sometimes with the veteran at their home or at some place where the veteran is comfortable?

A. Yes. If we can, we will try to meet with the veteran in their own home because, of course, that gives you a greater opportunity or likelihood that the family will become engaged in the conversation. You can assess the physical environment and sometimes that's more comfortable for the veteran as well. But we will also meet in other locations. And certainly over the course of the last year and somewhat, we've been doing that kind of work over the telephone.

Q. Of course. Yeah. Things changed with the pandemic. I understand. So assuming that there will be case management and that a case plan will be developed, there has to be some kind of assessment at the outset so the case manager knows what's needed and what the limitations or barriers are?

A. Yes. That is correct. And, realistically, if we're moving into rehabilitation, in particular, there should be additional assessments in support of the case plan. So, for example, if the impairment or barrier is physical, then we'll probably have reports from a physician or, you know, a treating physiotherapist or something to support it.

If it's vocational, we have VOC specialists who will provide assessments and feedback. And if it's a mental health nature, we'll often have a psychiatric assessment or a psychological assessment. And those assessments are required, really, for a rehabilitation plan to help guide that plan, identify the barriers and the strategy to address or mitigate the barriers to re-establishment.

Q. So if a veteran comes to a case manager and it's contemplated there will be case management, and let's say it's a mental health issue, say it's post-traumatic stress disorder, for example, will the case manager have access to documents or

assessments that have already been done or is a new psychological or psychosocial assessment done and ordered by the case manager? Where does that assessment come from that informs the case plan?

A. Right. Often, there is an assessment done as part of a, say, disability award application or pain and suffering application. And if that assessment is completed, we are able to utilize that assessment as part of a decision around rehabilitation. And, in fact, when you sign the application for, say, a disability award, there's a clause in there that says, The resulting assessment may be used to assess you for other benefits such as the rehabilitation plan. And don't quote me on that, but that's more or less what it says so that we can utilize that assessment to move forward on a rehab application as opposed to getting a new assessment, of course.

Q. Right. But if a soldier, for example, has been treated for PTSD in the CAF and then comes to Veterans Affairs, may be a long record of medical treatment, assessment, that type of thing. The case manager is not going to get that unless the veteran consents? It's not an automatic thing?

A. So if there is an assessment with a diagnosis, we can access that. But because we operate on a need-to-know basis,

the case manager does not have full access to go in and peruse through all of the documents ... health records that would be on file for the veteran. The veteran can specifically give them authorization to look at something specific.

But, as an example, for the purposes of the rehabilitation plan, if the diagnosis is required for post-traumatic stress disorder and there is an assessment that diagnoses that, we can use that assessment. But we don't necessarily have access to all the other background documents that, you know, may have been accumulated over the years of service with CAF.

Q. And the case manager, similarly, will not have access to if there are any provincial health records, again without the veteran's consent?

A. Exactly. They would require consent from the veteran.

Q. If a case manager determines ... they meet the veteran, they determine that case management is appropriate, you said the develop the case plan with the veteran. They both own the plan, I guess. Is that a fair way of putting it?

A. So, yeah, it's a collaboration between the veteran and ...

Q. Right.

A. ... the case manager and, often, other treatment

providers. So everybody has a piece and investment in the plan.

Q. So the case manager is going to be in consultation with the veteran, determining what services are appropriate. And you've mentioned an interdisciplinary team and also mental health officers. Are those resources that the case manager goes to in trying to figure out what might be appropriate for the veteran?

A. Yes. So VAC has a series of resources. Within an area office, there are health professionals, nurses, physicians, and occupational therapists. And that forms part of this interdisciplinary team, along with the case manager and the veteran service agent. And so cases will be presented there.

(14:10)

Discussions will occur on strategies going forward or whether or not, you know, a particular proposed treatment is a good idea. So you get the input of other health professionals and other folks around the table. It can also be less formalized. For example, the case manager may bring an assessment ... the nursing assessment to our nurse and say, Look, can you please take a look at this. Tell me what you extract from it for recommendations? So it can be less formalized.

Outside of the area offices, we have another network of resources and that's ... an example was the mental health officer. We have policy experts and we have experts in case management that we can consult as required when we're dealing with more complex or difficult cases.

Q. If a case manager, after doing that consultation, feels that a particular service would be very helpful to the veteran and the veteran is resistant ... and I understand that rehab is voluntary. They don't have to do it if they don't want to. But to what extent can a case manager ... I don't want to say "push" a veteran, but encourage them to engage in a particular service that they know would be beneficial for them?

A. Okay. So at the end of the day, we have no authority to force someone to attend. But if it was considered non-compliance or non-participation in the rehab plan, then theoretically we could put the plan on hold and say, Okay, well, if you're not willing or able to participate at this time, then we will ... we could potentially terminate the rehab plan, which could have financial impact for some veterans; others, maybe not necessarily. So that's one thing we could do.

In all likelihood, what we try to do is strategize with the veteran around what they would accept. So, for example, if a

recommendation is for inpatient treatment somewhere and the veteran feels that they can't participate in inpatient treatment because of family reasons or what-have-you, what we would try to do is strategize around what we could do in the meantime to support that veteran in the current environment.

But, again, it requires participation from the veteran. So they can't ... they have to be a ... they have to be involved in that strategy and what will work versus the proposed treatment. And so we'll often work with the veterans and/or local treatment providers to see if we can find another route to meet their needs.

If the veteran is completely unwilling to participate, well, that's a different story and then we would end up theoretically terminating the plan or at least advising them that if they continue to not participate we'll have to terminate the plan ... the rehab.

Q. And if the decision is that a veteran will access a service provider in the community, say a psychologist, you had said that the most that the case manager typically will do, maybe ... might give them a list. But, for the most part, they are going to find their own service provider in the community?

A. Right. So as public servants, we can't show

preferential treatment to a private provider. So, for example, I couldn't refer all of my clients to one psychologist in town because that could be perceived as a conflict of interest. That's one reason why we don't pick the treatment provider for them.

The second reason is what we're hoping will happen is a natural expansion of community supports. And so while there may be a new psychologist in town who doesn't have much of a background in treating veterans, if one of our veterans chooses to see that psychologist and they develop a good rapport, in turn, we may be creating a new expert out there in the field where other veterans may take advantage. So we're creating a market that's open for providers.

We encourage providers to engage in veterans and to take on veterans because it facilitates that learning and understanding in the professional community; in fact, offers support, as well. When you're a psychologist and you take on a veteran who has a case manager, then you're taking on, you know, a client who has someone else who's looking out for him, who's trying to encourage him to participate in treatment. And, potentially, you can access other resources like OSI clinics or experts in VAC who can help.

Q. I understand the benefit of developing expertise, especially in rural areas where the numbers may be smaller. But if, for example, a veteran needs treatment for trauma, like say for post-traumatic stress disorder, and they choose a therapist who really has no experience in that or limited experience, is it in any way incumbent on the case manager to suggest that other therapists might be a better choice?

A. So case managers are not experts in psychological treatment interventions or modalities and so they ...

Q. No, but ...

A. ... they wouldn't have that set of ...

Q. ... they would have access, for example, to your interdisciplinary team or mental health officer and they might understand who would be best, based on that advice.

A. So there may be, in a particular client's situation, that someone that has, you know, a very unique set of symptoms or conditions, it is possible that we might say, Well, this particular provider is probably going to be the best for them. And we may encourage somebody to go to one particular provider because of the uniqueness of the situation.

But if someone chooses another provider and that provider is not, let's just say, an expert in the treatment of trauma,

take your example, our case managers are going to be working with their client. They're going to be assessing their progress in the treatment because, of course, a psychologist is going to be supplying updates to the case manager as part of the plan and, hopefully, having discussions. And so one of two things will happen.

The provider may say, I'm not in a position to treat this individual. And, typically, we'll ask them to re-refer them to somebody else in the community, so another psychologist who they know is able to or has that skill-set. And/or the other thing that could potentially ... or we may work with the client to help identify another resource.

And/or the other thing that could happen is over time if we're not seeing progress with the case, we may connect with the client and ask them what their opinions are, if they'd like to try somebody else. We may connect with the treating provider and say, Hey, we notice there hasn't been any progress in this individual's file in the last year. Have you considered out ... or inpatient treatment? Have you considered connecting with our OSI clinics which has a set of expertise in the treatment OSIs?

So we're not experts but we'll monitor progress. And if we have concerns, certainly we'll discuss them with the client. If

those concerns are voiced to us by the provider, we'd ask the provider for help in finding somebody else, typically. And if they can't, then we'll go back with the client and provide a list again and try to work with them.

Q. It's incumbent on service providers to ... if they're being paid, to provide updates regularly or progress reports for clients?

A. Yes. Yes, it is. Yeah.

Q. And similarly, if a client goes to an inpatient residential facility, like say the OSI clinics, would there be regular conversations between the case manager and whoever the team lead is, let's say, at the OSI clinics?

A. So, yes, there would be regular communication and coordination with ... just for clarity, at the OSI clinics, that's not inpatient. That would still be outpatient. But, yes, we would be connecting with the provider there or the team of providers there and getting updates and direction.

Q. Okay. Typically, a discharge summary would come from an OSI clinic when the patient leaves or when the client leaves?

A. So ... yes. Again, because I want to be clear. OSI clinics tend to be outpatient treatment. Residential treatment is something we contract out separately. Both could potentially

have discharge summaries.

Q. It would be expected that those would come to the case manager, I assume, would it?

A. They should.

Q. Okay. Just on the issue of clinical care managers, the determination as to whether a clinical care manager is appropriate or not, is made by the case manager and that's typically in consultation with the subject matter experts, as you say, the interdisciplinary team or whomever the case manager consults internally, is that correct?

A. Yes. So the authority to approve is the authority of the case manager but we strongly encourage consultation with the interdisciplinary team or subject matter experts in the organization. It would also be a conversation we would, in all likely have, with a treating professional. So if somebody was engaged in psychology, then we would want to make that part of the discussion, with the client's permission, of course, with the psychologist in terms of planning what those outcome measures we would expect from the clinical care manager would be. And as I said previously, sometimes a recommendation from a clinical care manager actually comes from the external treatment provider.

LEE MARSHALL, Cross-Examination by Mr. Murray

(14:20)

Q. Okay. Right. So if the case manager decides that the clinical care manager is appropriate, you said that person or that potential clinical care manager, first of all, has to be registered with their own body, be they a social worker, what-have-you. They also have to be registered with Blue Cross Medavie as ... or I guess on the list for people who could be clinical care managers, is that correct?

A. That is correct, yeah. They register specifically as a clinical care manager. So I could be registered as a psychologist but I would separately register as also a clinical care manager.

Q. Right. And I think Ms. Ward asked a question along the lines of, do you have a sense of how many people are registered as ... potentially as clinical care managers. Have any idea of the numbers especially in rural areas? It's a fairly general question.

A. I don't ... yeah. I don't have it based on specifically rural areas. I did a little bit of reading. I could tell you that I think in my area, we have about 170, but I couldn't tell you where they are actually located. But it's not uncommon for us to pay for travel associated with the clinical

care managers because they will often meet the veterans in their home or other locations. So it is within our ability to pay for travel for the clinical care managers as well.

Q. Okay. So you said 170 in your area. That's in the three provinces, Newfoundland and Labrador, New Brunswick, and PEI?

A. Point of clarification. That's 170 active clinical care managers right now. I think ... and I've read this, but I can't say it with certainty, but there's somewheres around 360, I think, is the number. So one of the things to keep in mind is just because somebody is a registered clinical care manager does not mean that they are engaged in services as a clinical care manager. They simply register. But if we don't make a referral or don't need those services in that particular area, they may never actually take on a clinical care case. Right?

Q. Right. So the 360, you said, what area is that?

A. That's ... I'm speaking of my ... again, my province. I think there's somewheres around 360. And, again, this is something I read some time ago, so I'm not really comfortable saying it with certainty.

Q. Yeah. Fair enough.

A. But there are more clinical care managers than there

are clinical care managers actively working. And I don't have them by location. If I required it by location, I could certainly go to Medavie and ask for a list of registered clinical care providers and then I would know more or less what locations they're willing to serve.

Q. So I take it there are a number of people who are registered potentially as clinical care managers who never, ever get chosen to do the job or never get retained.

A. That's right.

Q. Okay. And if a person is retained as a clinical care manager, they have to get registered in the BHSOL system, right, the Benefits Health System On-Line ...

A. That's ...

Q. ... System? Is that ...

A. That's correct.

Q. ... sometimes a bit of a bottleneck getting that training; you know, getting up to speed on that? And, you know, when the need ... presumably, if a clinical care manager is needed, they're needed fairly quickly. Right? Is that an issue?

A. So, ideally, our clinical care managers have already worked with us and have had the training and so our referrals

are somewhat fast. But if it's a new provider, it does take time to get that provider registered and then coordinate the training to ensure that ... and to give them access and to ensure they have the training as to how to use that access for the BHSOL system.

Q. And can clinical care managers start doing their work prior to being registered on the BHSOL?

A. I'm not certain on that question.

Q. Okay. Do veterans ... clinical care managers are individuals who have training such as social work, occupational therapy and so forth, but they're not really engaged in that work. Maybe an OT to some extent, but say a nurse or a social worker, they're not engaged in basically what they're trained to do. Do veterans understand what a clinical care manager is supposed to do for them and ... or is there sometimes confusion about the role of the clinical care manager?

A. So in order to have a clinical care manager, that requires an in-depth conversation between the case manager and the veteran, to start, to establish, This is the service I'm going to engage for you and this is why I think it's required if you're willing to engage.

And the second piece to that is the clinical care manager

then meets with their client and goes through their role again and helps narrow the focus in terms of what they're setting as their goals. And then that agreement between the clinical care manager and the veteran is then submitted to the case manager for approval through BHSOL.

So, theoretically, there are at least two conversations to clarify the role of the clinical care manager. It is possible that there can be confusion. And I can tell you that our department has taken steps to clarify the roles of clinical care managers with our own staff through, you know, clarification on the short-term duration, specifying what the service should be used for, those types of steps. So I hope that answers your question.

Q. Yeah. No, no, that's fine. Is there sometimes ... from the point in time that it's decided that a clinical care manager is appropriate to the point in time that the clinical care manager actively starts engaging with the veteran; you know, helping them do things, do you have a sense of what the turnaround time is there, how often ... how long that takes, typically?

A. So once they're engaged and, as I said previously, it's typical for us to approve them for 90 sessions. Then,

really, it's a matter of the clinical care manager and the veteran scheduling their appointments together. And it should be fairly quick. Once they've been established, they should be able to meet regularly. And that's really a decision between the clinical care manager and the veteran.

Of course, if over time the veteran voiced that they were unsatisfied with the service, then the case manager might engage the clinical care manager and ask for more frequent visits or something of that nature. But, typically, not unlike psychology or another service a veteran might organize for themselves, it would be up to them to work that schedule out with the clinical care provider. But once they're approved for services, they can go.

Q. All right. So I assume there can be delays, again depending ... and this may be more of an urban/rural divide. But finding the appropriate clinical care manager, if it's a rural area, may be more of a challenge than it would be in an urban centre. Is that fair?

A. Absolutely. There would be less resources in those domains in smaller communities.

Q. You had said that the clinical care manager is obviously ... the idea is that it's for a limited period of

time. If after ... I know you said it could be three months up to two years. But if after a period of time the veteran is still unable to just meet the basic functioning needs of daily life; you know, filling out forms, getting to the bank, doing groceries, I don't know what ... all of those things, what is it that sort of says to the case manager, This isn't really working. We need to try something different. We need different interventions. How does that happen?

A. So if the service has been ongoing and the case manager continues to approve sessions, then a big part of what they'd be doing is consulting with their subject matter experts, which would be, you know, experts in case management or mental health or in policy, as well as their interdisciplinary team. I would expect them also to consult with the treatment provider, so the psychologist, psychiatrist, or whoever else is engaged with this veteran.

And, in all likelihood, they would organize a case conference to have a conversation about, If this isn't working, what are our next steps? What you're referring to would be a very complicated, difficult case. So there's no, Oh, next step is this; for example, a cookie-cutter approach, because it's so complex. So there would be a lot of discussion, a lot of

consultation, a lot of review of what else is available to help the veteran get to where the veteran wants to be and, you know, the support he would require to do that.

(14:30)

Q. It's fair to say that in most cases where a clinical care manager is retained, they are the complex cases. Is that a fair statement?

A. So I would say yes, but I wouldn't say that all complex cases have clinical care managers, but, certainly, if a clinical care manager is assigned, it would imply that there's a lack of progression with the case plan, that there's potentially an overuse of, say, emergency services like emergency mental health or emergency rooms or, yeah, the veteran has multiple health conditions that are cumulative in nature, preventing them from doing these things on their own. So, yes, complex cases get clinical care managers, but not all complex cases require a clinical care manager. It's specific to the needs of the individual client and, of course, their willingness to participate.

Q. Do most veterans for whom a clinical care manager is retained ... you said the maximum is 90 occurrences, I think you said, or thereabouts. Do most veterans use that all with their

clinical care manager?

A. So I don't have data on that but I can tell you that it is not uncommon to utilize the 90 occurrences and to extend, if required. And, as I said, we've got clinical care managers in place for three months and we've got them in place for up to two years, but I don't have raw data for you to tell you what the average is or anything of that nature but VAC will, in most cases, continue to extend a service assuming that it's of benefit to the veteran and the veteran is willing to continue, at least until another strategy or service can be put in place. Or, sometimes, it's family or social supports that end up taking that role on, too, to support veterans.

Q. You had said, in answer to a question ... and we recognize this, that VAC is not the holder or the keeper of a veteran's medical records. They may have some, VAC may have some, the case manager may have some, but they're not the holder of those medical records. You said, though, that you also are encouraging veterans to ask for their whole CAF medical record when they leave the Canadian Armed Forces. Is that correct?

A. Right. So I have a friend who is currently releasing and he asked me for some advice and my advice to him was, Get a copy of your medical service records because when you go to

apply, rather than having to fish out those documents ... Say, for example, you have a knee injury that happened when you were two years into service, and 20 years later, it starts to become a problem. If you have a copy of those records, you can present those records as part of your case and it would just expedite the whole process for you.

Q. Right.

A. So I would encourage someone to get them but VAC and CAF are working very closely together so that we can access them as required in a timely fashion and we are scanning those service records now, today.

Q. Okay. And part of what we're grappling with here at the Inquiry is the sharing of medical information where it's appropriate so that health care providers can know what happened before to veterans and members of the Canadian Armed Forces. I'm wondering if you see any potential role for either a case manager, or a clinical care manager, or someone else, a veteran service agent, someone else at VAC, to assist the veteran in, number one, getting their records from CAF and consolidating those and maybe providing them to a health provider in the province in which they live? Do you see any role for that or any way that VAC employees could assist veterans in that so that

doctors who are treating them are able to access those records more easily?

A. Right. So I think the important piece or component to that is "need to know". And, really, VAC's access to personal information is need to know, so we, if we need it, it's for the determination of a benefit or a service. And keep in mind that VAC is in your life, but once we're done with rehab, a veteran may move on and we may never have contact with them again, theoretically. Or they may only call us once a year and call the NCCN for something simple.

So we are not necessarily with the veteran throughout their life, which is why I would recommend to a veteran, Get your service records. You can put them in a folder. If medical service ... for instance, if you go to a new province and you get a new GP, you can hand them that file yourself and then now it's part of your medical record. I would think there would be a lot of risk for sharing of information that VAC doesn't have a "need to know" if case managers actually intervened and held on to those documents from an access to information privacy perspective.

Q. Right. And I guess what I'm thinking about, obviously, would, number one, always be with the consent of the

veteran, and, number two, I'm not suggesting that a case manager, for example, would hold on to a veteran's medical records forever. I guess I'm thinking more of a process wherein a VAC employee would simply provide assistance to a veteran in getting their medical records to their doctor in the province where they're finally locating. Something like that.

I appreciate what you say about a veteran having it in a folder and bringing it to their family doctor, and that makes sense, but if a lot of these veterans are having difficulty navigating the basic, you know, requirements of day-to-day living, you know, doing that may be a greater challenge than it may, on its face, seem, and I'm just wondering if there's a role for VAC in just helping veterans do that?

A. 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.

Q. Okay, fair enough. Is there, to your knowledge, any

cultural competence training that's going on with VAC employees dealing with veterans of various racialized communities?

A. So, currently, we have courses like CAF-101 and CAF-102 which are courses to familiarize veterans ... sorry, not veterans, VAC staff, with the CAF culture, lifestyle, ranks, those types of things, and part of that involves actually meeting a veteran and having a discussion with them about their experience and who they are and so forth.

In terms of specific cultural awareness, certainly, at the Government of Canada level, I know there is plenty of discussion about sensitizing really all public servants to different cultures or aspects of culture. I'm not aware of anything particular that VAC does right now.

Q. And you had mentioned earlier some, I guess, increased awareness, and I don't know if it was training or at least some thought being given to being more sensitive to issues of domestic violence. I don't know if there's more to say there or not but is there any training or anything in that nature that assists VAC employees who are dealing with veterans to, I guess, be cognizant of the risks of domestic violence, the telltale signs, those types of things?

A. Right. So we do have training around dealing with

veterans who are angry or exhibiting anger. We also have security training on what to do in situations of threat of violence or self-harm, and we also have the ASIST training and the suicide protocol. Specific to domestic violence, I am not aware of anything we are doing today specific to that, however ... Sorry, let me rephrase that. Nothing specific we did up until now, but, this year, as part of **Bill C-65**, the implementation, and that's to address harassment and violence in the workplace, there is mandatory training for all VAC staff, and part of that training does discuss domestic violence in relation to the work environment, but not necessarily just the work environment. So there is some training today, and that's this year.

Q. Okay. My friend, Ms. Ward, asked you what happens when there is, unfortunately, a suicide by a veteran, and you said there's no statutory review, nothing mandated by law, but there are informal, typically, or always informal reviews, are there, when there's a suicide?

(14:40)

A. Yes. So there's a business process to ensure there's an informal review, which is basically an overview summary of the file and that would sort of gather pertinent information

related to the file and, at that time, if there were any glaring errors or concerns, they'd also be identified in that process.

As you can imagine, then, at the local level, there is lots of discussion and review with the folks who are engaged in that file to support them and to, you know, walk them through the process and how things went but, again, it's ... the only formal process is the informal review which is a business process.

Q. And that's if you become aware of a veteran's suicide? There may be situations where a veteran may commit suicide and VAC may not be aware of it?

A. That is possible, however, with media and so forth, if we become aware of it after the fact, we will still take a look. If someone is being case managed then, typically, we will find out, if not from a family member from, you know, local media, et cetera.

Q. Right. And that informal review is done at a local level, is it, or at the area office, or is it done more broadly?

A. No. It's done by a national entity, and so it wouldn't be the local folks involved in the case. It's somebody externally who works for the Department who would review the file and the case and then present that to senior management in VAC.

Q. Okay. And they would access information from the CSDN, I take it? That's where ...

A. Yes.

Q. Okay.

A. Yes. So they would access it through CSDN and, today, they would also access it through GC Case and any other systems that may have information, although they would be the primary places to look for information.

Q. Right. And individuals who worked with the veteran would be a part ... well, would they be talked to? Would there be discussions with those if there was a case manager, for example?

A. Yes, there would be follow-up. So the process right now is that one of our subject matter experts would be assigned to the case manager and follow up with them to have a discussion. You know, as you can imagine, it has a great impact on VAC and the individuals working with the file as well. And so there's a care and compassion aspect to it where we would try to support those individuals.

Q. I assume it would be tremendously impactful for the case manager if one of their clients were to commit suicide.

A. Yes. You know, these are health care professionals,

social workers, and nurses whose vocation is to care for people, and many of our employees are either former CAF or family members of CAF, so it affects the entire team really. It's not just impacting one individual.

Q. And then that informal review, you said, is shared, I guess, up the ladder, if you will, with the ... you said the Director of Strategic-something. I'm not sure what the person is exactly.

A. Yeah. I apologize. The title has changed and I can't say with certainty what the new title is but it's basically a senior manager who reports to the DG of field operations and they will review that document.

Q. And, presumably, sometimes when that informal review is done, it's determined that nothing really needs to change or nothing should come of it. There may be times when there are recommendations for a change in business process or a change in procedures, is it?

A. So I've never personally been involved in the process, just because of my position, so I can't really comment on what would happen.

Q. Okay. The idea, though, is that that's the nature of the review is to determine if things can be done differently, or

better, or if changes are appropriate? That's the goal of the review, is it?

A. That's one of the goals of the review, to identify if there's anything that could be changed or improved on, I guess, yes.

Q. Okay. I think I'm just about done. You had mentioned a couple of little things. The My VAC Account, what can a veteran ... what's stored there and what can they access on that?

A. So I am not a foremost expert on My VAC Account, but a veteran can access their personal file on My VAC Account, so it's their profile. They can see what's happening with their benefits. If they have an application in process, they can track it. They can make application to certain benefits in My VAC Account, for example, health-related travel. So if they were making a claim for health-related travel, they can do that through My VAC Account, and the piece that I had referred to specifically is something called "Secure Messaging". So if you want to submit a question or information, you can use Secure Messaging. So the veteran, from their phone or from their own home computer, can input a secure message and it goes through My VAC Account, and either the National Contact Centre Network will

answer the question or it'll be referred to a specialist, say, who would be in a position to do it, and that could be a case manager.

Q. When a person is case managed, is there ... I know you said that sometimes case managers are dealing with veterans every single day; other times, they might go some time, depending on the needs of the veteran, without speaking to them. Is there sort of a maximum period of time that can pass without a case manager speaking to a veteran? In other words, is there a rule you have to call them every month or every three months, something like that?

A. So 90 days would be the, you know, recommended longest period of time somebody goes without contacting a veteran, but, more often, it's more frequent than that, but up to 90 days depending on the status of the veteran and their particular situation.

Q. Okay.

A. And, actually, I'm just going to specify. In 2015, I can say that it was 90 days. I'm not sure if that's ever been reviewed - to my knowledge, it has not - as the maximum period of time, but, certainly, in 2015, I can say with certainty that it would've been 90 days.

Q. Okay. Just one moment, Mr. Marshall.

All right, thank you, Mr. Marshall. Those are the questions I have. Other counsel may have questions. Thank you.

A. Thank you.

THE COURT: Mr. Anderson? Ms. Lunn?

MS. LUNN: The Crown has no questions for this witness, Your Honour.

THE COURT: All right, thank you. Mr. Macdonald?

MR. MACDONALD: Yes, thank you, Your Honour.

CROSS-EXAMINATION BY MR. MACDONALD

(14:47)

MR. MACDONALD: Good afternoon, Mr. Marshall. You can hear me okay?

A. Good afternoon.

Q. You can hear me okay?

A. I can. Can you hear ...

Q. Yes, I can, thanks.

A. I can. Can you hear me okay?

Q. I can, thank you.

My name is Tom Macdonald and I'm the lawyer for the Borden family, so they would be the mother, father, brother, of Shanna

Desmond, and the grandparents and uncle of Aaliyah Desmond. So I have a few questions.

Have you ever spoken to Ms. Doucette, you, personally, about this situation?

A. No.

Q. Okay.

A. No, I have not.

Q. Are you aware today ... so we've had what I'll call "the Desmond incident" four years ago. Now we're four years into the future. Are you aware today of any barriers that either your case managers or veterans accessing case management services still face?

A. I'm sorry, I'm not quite sure I follow your question. Could you rephrase it?

Q. So I'm asking you whether you are now aware, in the last four years, of any barriers that either your case managers feel they face, or veterans feel they face, in dealing with VAC? Barriers, you spoke of barriers, yes.

A. Okay. Yeah. So, certainly, we're working with case management right now trying to reduce the administrative burden, so documentation, interface with our systems, which takes time, time which we would rather have our, you know, skilled staff

dealing directly with veterans.

Q. So what can ...

A. And ...

Q. Sorry, please, yeah.

A. No. I was just going to say ... and, you know, I am aware at times of veterans who would've preferred a different decision on their benefit or would prefer an expedited decision on, say, a disability award or disability claim.

(14:50)

Q. Are you aware, though, of specific reasons veterans are giving that they feel are barriers that are in place, not necessarily deliberately, of course, but that are obstacles for them with the VAC system?

A. So identification and assignment of case managers, you know, veterans can benefit from timely assignment of a case manager. That could potentially be a point of frustration. Access to service providers. So we continue to have challenges in identifying resources in more rural areas, which is why we've done things like expanded telemental health because it's very difficult to create expertise in a rural area with a small population. So those types of frustrations I'm sure continue today.

Q. What about frustrations expressed by your case managers?

A. So, as I had mentioned, case managers would like to have less time interfacing with our systems and more time, face time or talk time, with veterans. And so we're trying to improve our systems. So I had said earlier today that we established GC Case, which is a new modality or a new system for recording case plans. We're currently implementing a new assessment tool. So the refinement of these tools is intended to not only assist in the documentation but take away some of the administrative burden for our staff.

Other things we're doing is trying to ensure more cohesive support from the interdisciplinary team. So we're engaging our subject matter experts, like nurses and physicians and OTs, in a more direct modality, I suppose, in case management, and that's to generate more support for our case managers. And we have other initiatives underway to close the seam, close the gap, so to engage veterans earlier in the transition process.

Q. Has there ever been thought given to putting in timelines? I understood in your evidence this morning, I think to Mr. Murray ... I get that there aren't timelines and I understood, you gave some explanation as to why there aren't,

but is there ever thought given to putting in some kind of timelines as a guide even?

A. So there are timelines for different activities, different decisions, et cetera.

Q. Yes.

A. And ... sorry?

Q. Sorry, yes. No, I ... sorry, go ahead.

A. I think, when I was answering the question, is could I give a specific amount of time it takes, say, to take a veteran from application to have them with an effective rehab plan in place? I don't ... we don't have a timeline, as such, around that, but I'm confident that if we delved into specific policy, there would be timelines around particular activities. As an example, if someone submits a message into My VAC Account, we try to ensure that that decision, or sorry, that response, occurs within a five-day period, just as an example of a timeline that we have in place.

Q. In your evidence this morning, you touched on the review process both with Ms. Ward and Mr. Murray, so I know there's this informal assessment at one end, and at the other end, there would be, in theory, a statutory review, if I can put it that way, but that's at a high end, if such a thing was in

place. There's an informal assessment and as opposed to a statutorily-mandated assessment, is there? There's two different kinds?

A. So there's an informal review when a suicide occurs.

Q. Yes.

A. In terms of statutory, we don't have a statutory regulation in place around a review in the case of a suicide, but, of course, VAC, we're always trying to improve. We're always improving our tools. We're always strategizing on more effective approaches. We're always trying to expand our services to veterans. And so, you know, we are constantly evolving, constantly improving, and just the change in the **New Veterans Charter** to the **Veterans Well-being Act** is an example of that. Trying to simplify things for veterans, trying to reorganize ourselves but, specific to suicide, I'm only aware of the informal review process.

Q. And are you aware then that informal review process is the only process informally within VAC? There aren't different levels of the informal review process?

A. So the informal process is the only process that I'm aware of.

Q. Okay. All right. You mentioned in your evidence this

morning to Ms. Ward about ... I think the question was asked. It possibly could've been Mr. Murray. That was about your case managers don't make decisions for the clients, for the veterans. Do you remember that? They don't make decisions.

A. So they don't make decisions on behalf of a client. They can render decisions around benefits for clients.

Q. Right.

A. But when it comes to case management, veterans ... we subscribe to self-determination and so, unlike Corrections, where certain decisions are mandated on behalf of the client, we don't do that at Veterans Affairs. We are on the side of the client and make decisions with the client and so, again, they're voluntary participants and they are decision-makers at the end of the day of what they choose to avail of or not.

Q. So what does your case manager do if they're dealing with a client who is mentally ill and either can't make a decision for himself or herself or can't ... at least needs some kind of help to even get to the point where they make a decision?

A. Right. So this is where we would engage, obviously, any treating providers, like a psychologist, et cetera. We talked about the clinical care manager, so that's a good example

where, if someone doesn't have the coping mechanisms or problem-solving skills at the time to implement their portions or their activities within the case plan, we might engage a clinical care manager to work directly with the veteran. That's one strategy.

Q. Okay. Can you think of any other strategies?

A. Well, ideally, what would happen is the case manager would hopefully engage the veteran and/or their family or support network. It's very important to have a strong support network, and so if we can engage the support network to help us with that, we will. Of course, again, the veteran has to be willing to include that support network in the discussions. So that might be another strategy.

Q. So when I sat here this morning and I was listening to you, which I thought, to me at least, was enlightening and you were explaining a lot of the workings of VAC and various acronyms and programs and assistance, a little daunting if you don't know the system. So my question is, is there anything in place, or should there be that, by way of navigation assistance to a veteran when they are discharged and they're now coming to Veterans Affairs for assistance, that sort of takes them by the hand, not unlike a patient advocate at a hospital, to sort of help them navigate the system? Are there supports in place

within VAC for that?

A. Yes, that would be our transition process. And so what we're trying to do is enhance that process to provide as many possible tools as possible for veterans to utilize during the course of their release. So release doesn't happen, you know, a decision is not made on a Friday and they're released on a Monday. Typically, there's a period of time where they're preparing for it. So part of that is the transition interview I talked about where we engage with them early and we get a sense of how much risk there is to a successful transition. And if, at that time, it's determined that somebody needs support, we will try to refer them to the supports in place.

Keep in mind that the CAF has its own support network in what we refer to as the "transition networks" now, and as ... there's a group of people surrounding the veteran and supporting that veteran in preparing for their release, and VAC is just one of those members.

So, certainly, there's a transition interview, and then referrals for further follow-up would be part of that hand-holding, if that makes any sense, and then we can also engage resources like, for someone with an operational stress injury, we might engage an OSIS peer support to work with or make a

referral to the OSIS if the veteran is willing to allow us to make a referral to OSIS.

(15:00)

Q. So once that transition assistance ends and the transition is complete and the veteran is going on within CAF and let's say the veteran is still having issues in terms of navigation, is that something then that is assisted by, clarified by the case manager or the clinical care manager, for example?

A. So if they're assigned a case manager, absolutely, the case manager would potentially work with them if there are existing transition issues. And, you know, at the end of the day, if someone is getting case management, it is because there is an injury or an illness, mental health or physical, that's creating some barriers to their ability to transition to, say, a civilian social network, civilian employment, or just civilian functioning. Functioning outside of CAF. Keep in mind that in the CAF, everything is more or less taken care of, whether it's your physician, your hearing aids, your where you're going to live and all types of decisions. Once you're released from CAF, even simple things like finding a doctor are things that, in often cases, veterans have to learn how to do that. So, yes, we

provide that support.

MR. MACDONALD: Those are my questions. Thank you very much, Mr. Marshall.

THE COURT: Thank you, Mr. MacDonald. Ms. Miller?

CROSS-EXAMINATION BY MS. MILLER

(15:01)

MS. MILLER: Good afternoon, Mr. Marshall. My name is Tara Miller. I am the lawyer representing the personal representative for Brenda Desmond, Cpl. Desmond's mother, and also share representation with Mr. Macdonald, who just asked you some questions, with respect to Cpl. Desmond's daughter, Aaliyah Desmond.

You've given us lots of background information today, which has been very helpful, and I want to try to put some of that background information into context with the specifics of Cpl. Desmond's situation. I appreciate that you were not involved but you do, as you've given your evidence this morning and this afternoon, you do have a firm grasp and experience with the process and the systems and the pieces that would play a role in the veteran's experience with Veteran's Affairs. Is that fair to say?

A. I have a significant amount of experience working with VAC, particularly in frontline operations, yes, that's fair to say.

Q. So in Cpl. Desmond's case, we understand that VAC's role with him transitioning from CAF into the civilian world really would have started with the transition interview that took place in May of 2015. I believe you said that VAC has sort of two roles when veterans transition from the CAF. The first is to attend the SCAN seminars. Those seminars are run by DND but you or VAC would be there to give information about resources, answer questions, et cetera. So that's the first place. And then the second, I would say based on what I understand your evidence to be, a more substantive involvement of VAC with a miliary member when they're transitioning into civilian world comes with this transition interview. Is that correct?

A. Yes.

Q. And at the time of the transition interview what information does Veterans Affairs have about the veteran or the military member at that point who is getting ready to transition out?

A. So it's the CAF that makes us aware of the

transitioning veteran. So it's really dependent on the specific individual. Where it's a very complex case and there are, say, a multitude of issues and CAF has flagged that person for more intensive care or treatment before release, we will often be engaged earlier. A case manager might be asked to be engaged early in terms of what the plan is going to be for that particular veteran. But most cases were basically presented with the veteran and main ... You know what? I don't have the, say, list of exactly what's provided. So I'm not going to pretend I do. But we would know who they were, that their release category was, and likely have some introduction because these often occur or can often occur at the transition centres on base. So we might be introduced to the veteran in that way, although transition interviews can occur simply through a referral through CAF via kind of email and then we contact that veteran and would follow up with him. Keep in mind that if that veteran has ever applied for services, say, for example, a disability award or something like that, then we would have that information on our client service delivery system. So, in all likelihood, a veteran service agent who was doing that transition interview would read whatever we had on file ... Well, not whatever, they wouldn't be able to read service

records but they would potentially know that what the veteran received in terms of benefits from VAC, where they live, and whether they're married, that type of data, if we have a file already for the veteran.

Q. And are you able to say, Mr. Marshall, whether or not Cpl. Desmond's case would have been flagged by the CAF as a complex case at the time that they identified it for Veterans Affairs?

A. I'm sorry, I'm not, without knowing the specifics of his file, I wouldn't be in a position to do that.

Q. Okay. The transition interview is found at page ... or, sorry, it's Exhibit 278 and I believe you reviewed it or it was put to you earlier today, but I'll have that brought up, just so that we can go through that document.

I'll just zoom in and we'll move through it and I'll identify where we're going in terms of the document, but on the first upper portion of the first page, we see sort of one-third of the way down, it says, "Does the member have a CAF case manager?" And the answer is "yes". And then it says, "If, yes, provide name of CAF case manager." And the name is listed there as a Ms. Bates.

Do you know where that information would have come from,

Mr. Marshall, in terms of the transition interview? Would that have been something that came from the member, in this case, we're looking at Cpl. Desmond's transition interview, or is that something that would have been flagged for Veterans Affairs by the CAF?

A. So I don't know specifically for this case. Either of the two could potentially be true. It's possible that the referral came through the CAF case manager and they had made contact with VAC previously, but it's also possible that the veteran disclosed that at the time of the interview.

Q. What, if any, interaction is there between the CAF case manager and the VAC case manager through this transition period moving foward, generally speaking. I appreciate you can't comment on Cpl. Desmond's situation but, generally speaking, is there interaction, should there be interaction, what would it look like?

A. There certainly could be interaction in cases where it's warranted that this is a specifically complex case and the CAF case manager may engage VAC, particularly at the transition centres where they might engage a case manager and advise them of the circumstances. If that is the case, one would think that perhaps the case manager may have done the transition interview,

which is not typically the case but can happen. So, in this particular case, I don't know but it is possible that the CAF case manager reached out but not necessary.

Q. Did the fact that there is ...

A. But that ... Sorry, I was just going to rephrase. Not necessarily implied that they reached out.

Q. Does the fact that there was a CAF case manager suggest to you that this was a more complex case moving from the CAF system into the VAC system, or did that detail not mean necessarily anything with respect to the complexity of Cpl. Desmond's situation?

(15:10)

A. So I'm delving into DND policy. My understanding,, not being an expert in this matter, is that a medically-releasing member would be assigned a CAF case manager but that does not necessarily dictate that it was a complex case.

Q. Okay, thank you. We know from the first page, the bottom third, that this interview was conducted in person by the client service agent, Ms. Christensen. And you had indicated earlier that the member's encouraged to include family members in this transition interview. You gave us the reasons why that's helpful and we see, "Was the member aware he or she could

invite someone to attend the interview with him or her?" And the answer is "yes". But it's noted that there's no spouse or partner or other support in attendance with Cpl. Desmond at this transition interview. Have I interpreted that correctly?

A. That's what I read as well, ye. That he was aware, which is our practice, to ensure awareness. I haven't viewed the entirety of the document but if it says there was no one else in attendance then I'd have to accept that based on the document provided.

Q. I'm going to turn to page two of this exhibit. You mentioned earlier that VAC may have a file already in place at the time of a transition interview if the individual has applied for a disability award. Did I capture that correctly?

A. Correct.

Q. Okay. And that if that was the case, VAC would have access to that material through the VAC system in relation to the disability award.

A. So, yes, just a point of clarification and it's in the context of the way our system works. So if you apply for benefits with VAC, your tombstone information, your name, service number, those types, those pieces of information are collected kind of on the main page or the, you know, first page

of your electronic file. And so that information would be inputted because you had made application before. There are additional documents that potentially would have been attached to that disability award application. Assessments, service records, et cetera, that the veteran service agent wouldn't necessarily have access to or wouldn't access, even if they could access, because it wasn't a need to know. But, on that main page, they could tell who, you know, living situation, address, and there should be a list of what benefits they're currently in receipt of.

Q. Okay. Certainly we know from earlier today, Ms. Ward reviewed with you a summary sheet of different benefits that Cpl. Desmond had received and there were some lump sum disability award benefits. That would have been ...

A. That's right.

Q. ... in place in that period of time and through this transition interview. We see reference to disability award applications in progress for his lower back and another condition. That's at sort of middle of the page, on page two, member's health and functioning. And then under, "Does the member have any mental and/or emotional health concerns or issues?" We see that he reports that he already has a

disability award for PTSD and an application in process for MDD, which I understand to be major depressive disorder. Is that how you would interpret that as well?

A. Yeah, so it looks like he has a disability award at 35 percent for post-traumatic stress and an application for MDD, is major depressive disorder. That's my understanding of that abbreviation.

Q. Okay. I'm going to take you now, Mr. Marshall, to page six of eight, which looks like it's the final page of the transition interview just before the Regina Risk Indicator Tool. And I think that's in front of you. This looks to me to sort of be a summary section. It says, "Is this member at risk for an unsuccessful re-establishment and/or transition difficulties?" And the answer is "yes". And then under "Summary of Interview", it indicates that the Regina Risk score of 14 out of 65 makes him at moderate risk, and we'll come to that later. One of the things I wanted to address with you is about two-thirds of the way down, it says, "Client notes he fell on his head while jumping out of a plane but was never given a diagnosis. Client states he has trouble remembering things and retaining information. Advised client if he received a diagnosis for his head injury that he should apply for a DA", which I understand

to be a disability award. That's abbreviation. Do you see that?

A. I'm just reading it now, just bear with me. It's very small text.

Q. And the final sentence that I just want you to look at, it says, "Client advised he was told it was linked to his PTSD condition."

A. Okay.

Q. So would the individual who is responsible for conducting this transition interview have any responsibility to action any further, I guess, process in relation to being advised by Cpl. Desmond that he fell on his head but he was never given a diagnosis and trouble remembering things. Or this person just compiling information for somebody else to ultimately look at and address?

A. So if I read it correctly, it sounds like the person who did the interview, the veteran service agent, would have suggested that he consider applying for a disability award. And then it says, Client states ... Sorry. "Advised client if he received a diagnosis for his head injury that he should apply for a DA. Then client advised he was told it was linked to his PTSD condition." I'm not sure what that part means. I would

suspect that he's referring to a medical professional or someone that assessed him.

In this particular case, this information is captured and will be shared with the referral to a case manager. So the data and the score, of course, goes into the client service delivery or attached to the client service delivery network and should be part of the referral to the case manager.

In terms of follow-up, we wouldn't specifically say, Well, we're going to apply for a disability award for you. We do know that symptomology between head injuries and post-traumatic stress disorder can sometimes be similar and we've had presentations from researchers and so forth that sort of indicate that there can be similarities. Certainly the individual doing this interview wouldn't have the expertise to make that assessment. So it appears to me that they captured it to forward along with the referral.

Q. Okay, thank you. So what I understood you to say that they ... Any actioning of that would fall into the case manager to assess in addressing the plan moving forward with the veteran. There's a purpose for gathering this information and it's gathered so someone can assess it and address it at a later stage and that person is the case manager.

A. So certainly the context is captured. A case manager is not also in a position to say do further assessment or analysis in terms of what that injury is. But certainly they might suggest a referral to further assessment or they may engage with the current treatment provider and ask whether there is a need for further assessment.

Q. Okay. And a minimum, is it fair to say it's a flag for the case manager to look at and consider what needs to be done, if anything, to address the complaint of the head injury.

A. Well, I would say that the veteran service agent captured it for the purposes of ensuring that the case manager knew that that was part of what they disclosed during the interview.

Q. Okay. But with the expectation that the case manager would then make a decision based on their experience about what, if anything, was to be done in and around that information.

(15:20)

A. I think what I would say is it would really depend on the context of whether the current treatment providers were aware of that and if they had that context, which I don't know. But, for example, if they were seeing an individual and the treatment team, say the psychologist or the psychiatrist that

was treating them was aware of that and was satisfied that it was part of their post-traumatic stress disorder symptomology, then a case manager would, it would be highly improbable or unlikely that we would challenge that. If the veteran had zero service providers in their life, in other words, they weren't seeing anybody at the current time, then the case manager would likely ask for permission for the veteran to share that and they would encourage that veteran to share that information with their treatment providers.

Q. Okay. Just one final question on page six of Exhibit 278. The final line in that document, Mr. Marshall, in that box, says, "Provided client with rehab application and VIP application, as requested", in round brackets. Can you give us some understanding of what each of those applications are for? Firstly, the rehab application?

A. Right. So the rehab application would be application to our rehabilitation program, which as I briefly described earlier is a program where we would engage with a client to help address barriers to re-establishment caused by a physical or mental health conditions. And that program, of course, depending on what the barriers to re-establishment are, would address things from medical care to VOC rehab. There's an

income component. And, as I said earlier, it appears that this individual was receiving SISIP, so they wouldn't have got the income replacement portion. But that's basically application to the rehab.

The second portion, application to VIP is a veteran's independence program. So our VIP program is, I described it briefly earlier, it's a program that's intended to help veterans maintain independence in their own home. So it addresses mostly what we refer to as instrumental activities of daily living. So cleaning your house, mowing your lawn, shovelling your snow, those types of elements. And so it appears that they gave him that application to apply for those benefits as well.

Q. And follow-up on the completion and submission of the rehab application and the VIP application, would that fall within the scope of work for the case manager to follow up with and make sure that the veteran understood, to nudge or to encourage completion. I appreciate that the case manager can't do that for the veteran but is that fair to say that completion of those two things would be within the scope of what the case manager would be addressing with the veteran?

A. So, in this particular case, I believe the score was moderate risk, which would still be a referral to a case manager

and it would be typical for the case manager to review that information and then follow-up and say, Have you made your application to rehabilitation? Have you made application to veteran's independence plan? If not, you know, and have that discussion.

Q. Okay, thank you. And that takes me into my next sort of questions, Mr. Marshall. You had said earlier that with a score of 14, that was a moderate score on the Regina Risk Assessment and that would necessitate a referral to a case manager for review. I think you also said his score should have resulted in VAC work item for review of that potential follow-up assessment. What kind of a follow-up assessment would you have expected been done following completion of this transition interview and Regina Risk score on May 25th, 2015?

A. So contact would have been made by a case manager, potentially to have a discussion about whether the veteran, how the veteran was, you know, doing with their transition, whether or not they had completed the applications. The case manager may at that time decide to do a full on assessment and do another RRIT, but not necessarily. They may have a discussion and see where the veteran is. Potentially, a veteran could say, No, I'm good, I've decided not to apply, everything is working

out but I know how to reach you. Or the veteran could say, Yes, I want to proceed, and then the case manager would arrange to meet with them, do a full assessment. Because the assessment, as I said earlier, typically will occur in the veteran's home and it's a fairly labourious process. It covers all of the areas, say, that the RRIT covers but in more depth and it's a part of that understanding the situation to determine what the next steps are. Assessments often result in an engagement and case finding but not necessarily. At the end of an assessment, a determination could be made that, you know, no further services were required or, potentially, targeted assistance, like maybe they would have approved veteran's independence program and then the veteran would have went about their way and re-engaged us if they required it later on.

Q. And you talked earlier about the timeframes around assigning case managers. There's certainly best practice but then there's the reality in terms of resources, which at that point I understand were more limited than they are now currently. However, notwithstanding that, given that you understand this moderate rating would have necessitated a referral to a case manager, what would you have expected the timeframe around that step to have been, Mr. Marshall?

A. As I said previously, you know, the earlier we can engage a veteran, the better. Because of course, you know, time and getting in early is certainly of value in any kind of transition or rehabilitation process. Having said that, it is really dependent on how many other referrals are in the queue at that particular time. And if there were, you know, 10 cases where the RRIT-R score was at risk or high risk, then theoretically a manager would assign those cases first. So the timeline is really dependent on their environment and how fast that they can assign it to a case manager. Ideally, the sooner we can assign a case manager, the better.

Q. I'm going to take you now to Exhibit 273 and this is, as I understand from your earlier evidence, these are the client service delivery notes that exist or I think the acronym is CSDN. These are the notes that exist under each veteran's file. So we know, of course, that the risk assessment and the transition interview were done on May the 25th, 2015. And I'm going to go to page 19 of Exhibit 273 and we'll move back. And I'm looking at perhaps the bottom half of page 19, Mr. Marshall. And this is sort of taking the general and putting it in the specifics of Cpl. Desmond's experience. I'm looking at a note four up from the bottom and this is date created May 25th, 2015

at 11:57 and we see reference to the transition interview, which I assume correlates with the transition interview document that we saw. This is the date it was done and this is entered into the ... This is a major event and it's entered into the client service delivery notes, correct?

A. Right. So the notes reflect certain activities like transition interviews and screening so that if you're going through the notes, you're aware that a transition interview was completed at that point in time and you would go to a separate area to access that document that we already reviewed.

Q. Okay. And what I understood you to say earlier that with the risk assessment score of 14, that that should have resulted in a VAC work item for review of that and potential follow-up. So would you have expected to see in these notes in and around this timeframe a work item generated for referral to a case manager?

A. So work items aren't necessarily reflected in client notes. That would be a separate page and a separate list of activities. So they wouldn't be necessarily reflected in the client note. However, if say a work item was referred to you and you actioned that work item, you may document the response to that work item in client notes.

(15:30)

Q. Okay. So I see no reference ... and I appreciate you ... I don't ... well, have you reviewed this package of notes relating to Cpl. Desmond? No.

A. No.

Q. Okay.

A. No, I have not.

Q. My review of the notes is that there is no reference to a case manager looking at this for quite some time. But we see, if we go two items up ... we see that on June 25th, Cpl. Desmond comes in to CFB Gagetown and he submits his completed rehab package. I'm assuming that's the rehab package that was given to him at the transition interview.

A. It appears to be. Yeah.

Q. All right. I'm going to take you now to page 18 of 22. And I'm looking at the note at the bottom of the page. And this is a note dated August 31st of 2015. So we're now three months after the transition interview which took place on May 25th. And this is an NCCN analyst that says:

> Request for case management. Urgent.
>
> Client called. Released from the CAF in June 26, 2015 and feels he needs to be case

managed. Client has a DA for PTSD at 35 percent and having difficulty adjusting. Urgent work item to DO.

And then it goes on to say:

Client stated he was advised he would get a case manager a few months ago and is still waiting. Feels he has the need to be case managed. Answered a few of his questions regarding drug coverage and application status. Tried to warm transfer to get a case manager on the line for client, but kept getting voicemail. So I explained to him I would send urgent work item and if he does not hear from somebody from local AO by the end of the week, to call back. Client stated that he would.

Are you able to tell, Mr. Marshall, from this note if there was actually a case manager who had been assigned, at this point, to Cpl. Desmond?

A. I'm just going to re-read it to see if I can ascertain.

Q. Yeah. Fair enough.

A. Okay. So just one point of clarification and then I'll interpret for you. When it says "urgent work item to do", it's actually "work item to district office". And a district office is the same thing as an area office, which is reflected lower where she states, "Urgent work item and if he does not hear from someone from local area office by end of week, to call back."

So one of the things I can tell you about the Client Service Delivery Network is it will identify if case manager has been assigned typically. So when the National Contact Centre analyst gets a call and accesses a veteran's file, typically they can tell if that's occurred or not. So the fact that she does not say that there is a particular case manager assigned would imply to me that nobody has been assigned.

I do know, however, because I technically still the area director for New Brunswick, that sometimes case assignments were done via email outside of work items in CSDN. So it is possible that a case manager was assigned by receiving an email from, say, a veteran service team manager saying, Please access this file. You've been assigned. But there's nothing in this email to indicate to me that a case manager had been assigned at this point in time.

Q. Okay. Thank you. So I'm going to take you up the page a few more notes. And I'm looking perhaps at the bottom one-third ... or to the top one-third at the note of October 2nd, 2015, created by NCCN analyst at 16:23. And the note says: (CM (case management) manager followup from client. He's anxious to hear from one ASAP. (And then there's a phone number.) Please see note, 31 August note as well." And then there's a whole bunch of acronyms, Mr. Marshall, that maybe I'll ask you to interpret for us. "Supp-HP WI to SJAO." Can you give us some insight into what that line of letters mean?

A. I'm not a hundred percent sure on the "supp," but my interpretation of that would be "Submitted high priority work item to Saint John area office."

Q. Okay. So now we are coming up upon five months-ish from the date of transition interview and the risk assessment which indicated Cpl. Desmond should have had a case manager and it looks like he still doesn't have one by early October. Is that a fair assumption based on this note?

A. Based on the note, it appears that he hasn't been assigned a case manager, or at least hasn't been contacted by a case manager at this point in time.

Q. And then if we look at the note directly above, we see

October 14th, 2015 at 11:30. This is another NCCN analyst. There's ... the first note deals with a DA payment. And then the second note starts with "CM. Client following up on status of CM assignment. No new information. Info WI to AO." I interpret that to be work ... is that ... "WI" meaning a work ...

A. Work item.

Q. ... work item, thank you, to area ...

A. To ...

Q. ... office.

Followup re in progress work item from August 31st. Client still waiting CM assignment. Is anxious to be assigned, so he can speak with him or her. Please ensure progress for CM assignment is still ongoing. Thanks. ATCC.

Again, is it fair to say that by that date there's still no case manager, at least that's been identified in the system, for Cpl. Desmond who's now reached out three times.

A. That's how I interpret it. Yes.

Q. And I'm going to take you now to page 17 of 22, at the bottom of the page. I'm looking at a note, November 5th, 16:50.

"Position, case manager." It says, "File review as per CSTM. WI sent to CSTM as he is awaiting assignment to case manager." Does this give you any insight into the status of the assignment of a case manager for Cpl. Desmond through the VAC system?

A. I can't say I completely understand it. What it appears to me is that the individual was asked to review the file by a CSTM, which is the client service team manager or now we refer to as veteran service team manager. And then it says, Work item sent to the client service team manager as he's awaiting assignment to a case manager. But I can't say with certainty what exactly they're saying there, unfortunately.

Q. Okay. No. Fair enough. Then if we look at the note above, this is November 6, 8:15, created by a re-establishment program. And it says, "CF veteran eligible for rehabilitation program." And you may not be able to tell us that, but we looked earlier, on June 25th, at a note where it says that Cpl. Desmond dropped off a rehab package on June 25th. Do you understand this to be when his eligibility for that rehab program as a result of his application is approved?

A. I can't say with certainty, but that's how I interpret it, that this is notification that the veteran was deemed eligible for rehabilitation.

Q. So that's four-and-a-half months, approximately, after he dropped off his application for the rehab program. Is that, in your experience ... Mr. Marshall, is that in keeping with best practices or policy in terms of turnaround time for approving a rehab application?

A. No. Ideally, we would want to do this as soon as possible.

Q. Then the next reference to "case manager", I see is on the same page but at the top one-third. We're now November 19th and 10:29, "Position, NCCN Analyst. Doctor from the OSI clinic called to speak to the CM. Transferred over to her. MTLCC." And then directly above that, we see the first entry from case manager, Marie-Paule Doucette, on that same day. I'll give you a chance just to look through that, but my question, Mr. Marshall, is is this, from your understanding of Veterans Affairs notes, is this the date, November 19th, some six months after the transition interview, that we can definitively say that VAC has assigned a case manager to Cpl. Desmond?

(15:40)

A. So the note 2015/11/19, 10:29, what that implies to me is that a case manager has been assigned at this point. It doesn't necessarily mean that that is the point that the case

manager was assigned because if the case ... or, sorry, if the NCCN analyst is acknowledging "transferred over to her", then something in the system is advising her ideally that Marie-Paule has been assigned to the client at that point in time. So where the assignment actually took place, the point in time, I can't say with certainty. But certainly by November 19th, it was in the system that she was assigned to the veteran.

Q. And then if we look at the note above it, this is the first entry from Ms. Doucette. And the final sentence says: "Writer is in the process of familiarizing with file as the newly assigned case manager and will attempt to connect with the client as soon as possible."

But I take from that that Ms. Doucette was not assigned to this file for almost six months after the transition interview took place. We'll ask her this, but my understanding from this is that she's the newly assigned case manager. There's no indication that we've looked at, or you're aware of, that there was an earlier case manager. Is that fair to say, Mr. Marshall?

A. There's nothing I saw. And keep in mind now, the only portions of the file I've seen are what you've shown me. But based on what I've seen, this is the first indication that a case manager has been assigned.

Q. Okay. And then Ms. Doucette, once she is engaged, starts to work the file and does the assessments and does a new screening. And we'll deal with all of that when she arrives for evidence. But in fairness to Ms. Doucette, it looks like there was a six-month gap here when Cpl. Desmond did everything that was asked of him and followed up regularly, looking for a case manager and it didn't happen until six months after he should have been in the system for a case manager. Is that fair to say?

A. From what I read, it looks like it was that period of time before a case manager was assigned.

Q. And I want to circle back earlier to sort of ideal best practices in terms of assigning folks. I would suggest that six months is well outside the ideal situation for getting somebody who is identified for needing a case manager, has a rehab program that his application is well outside any acceptable timeframe for making sure he's moving through the system as he should have at that time. You don't disagree with that?

A. Oh, I'm sorry. I didn't realize it was posed as a question. It's not an ideal turnaround time in terms of assignment of a case manager. We would endeavour to try to

assign somebody at a shorter timeframe than that, most certainly. There are certain things to consider. For example, eligibility for rehab wouldn't exist until the veteran was released, which was still, based on what I saw, several months previously. And then, of course, familiarity assigning the case based on location, so forth, might take a period of time but typically does not take that much time. Today, I can't speak to how things were operating in New Brunswick in 2015.

Q. Okay. Thank you, Mr. Marshall. Those are my questions. Appreciate your time.

A. Thank you.

THE COURT: Mr. Rodgers?

MR. RODGERS: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. RODGERS

(15:45)

MR. RODGERS: Good afternoon, Mr. Marshall. My name is Adam Rodgers and I'm the lawyer representing the personal representative of Cpl. Lionel Desmond. So I have a number of questions for you, as well.

I wanted to start, Mr. Marshall, with the payment options and ... sorry, payment entitlement that Cpl. Desmond had. And

maybe we can bring up Exhibit 286 just to review this. As that's coming up, Mr. Marshall ... yes, that's what I was looking for. That's great. Thanks.

So we see some lump sum payments which were provided to Cpl. Desmond as a one-time lump sum payment while he was still ... before his discharge. And then I think we added those up. Yes. It's 126,000, over the course of five years, that he received there. And then I think you talked about the other financial benefits which are just below there, one being the S-I-S-I-P, the SISIP financial. And I believe you indicated, Mr. Marshall, that those benefits would be payable for approximately two years after Cpl. Desmond's discharge?

A. Yeah. So I just want to be cautious about that. SISIP is not our program. I certainly have no involvement in decisions around it. In general, my understanding ... and it's fairly common. In VOC rehab programs, that it's a two-year timeframe. But I'm not an expert on SISIP, so I would say in general that's my understanding. Yes.

Q. In addition to that in terms of ongoing payments ... ongoing financial support, Cpl. Desmond would have his retirement pension, which we see here at $862 per month. That's correct? That's what's on the form, I should say.

A. (Nods head "yes".)

Q. And so this would be payable to him immediately and then for the rest of his life?

A. It's his superannuation. If it's his superannuation, yes, that's my understanding. VAC is not involved in the superannuation either, so I ... you know, I'm not an expert, but I suspect it's very similar to my own superannuation. So payable until the end of your life and likely indexed in the federal ...

Q. Probably ... yeah. Probably indexed, as well. And then the other ongoing benefit that he would be receiving, we see above there, was the financial benefit, CIA Grade 3, which shows a disability payment that's ... as far as you can tell from the information, does that appear to be something that would be an ongoing payment, as well; in other words, an indefinite payment?

A. Yeah. So it certainly was ... in this particular case, it potentially could be reviewed and change over time, moved to a lower grade at a higher amount, et cetera, but certainly part of his entitlement, based on the impact to his career. As our programs change ... this program doesn't exist anymore. It's been replaced by ... it's one of the programs

that's been replaced under our new programs. So income replacement benefit is now indexed and intended to compensate for loss of career progression through the financial program. So it's a little bit different today. So it may not have continued in that particular matter, but somebody in benefit adjudication with, you know, more familiarity with how those programs were transferred to the new programs would have to answer that specifically.

Q. Okay.

A. But, certainly, that was part of his monthly income at the time. And if I may, I think it's also important to add that the lump sum payments, when an individual received lump ... sorry, received an approval on their disability award, they're given the option of ... three payment options. One is lump sum, where you get all the payment at once. Another option is to receive a portion of lump sum and then have annual payments that continue until the sum total is gone, or you can just have annual payments until the sum total. So, in other words, a veteran had the option ... or, in this case, he was still serving when he applied for PTSD. He had the option of having that payment paid out over increments versus all at once.

(15:50)

Q. After the lump sum payments were made and after the SISIP would finish in two years or thereabouts, it would seem that what Cpl. Desmond would have left would be his pension of 862 a month and his other payment of 592 for ... adds up to about $17,500 per year. I'll save you the math on that, Mr. Marshall. That's what Cpl. Desmond would have without any other sources of income?

A. So with the SISIP Program, if that were to terminate at the end of the two years, let's just say, but Cpl. Desmond continued to stay on the rehab program, he could apply for earnings loss benefits at the time. So, in fact, he would have received the amount that he was getting for SISIP post leaving the SISIP Program as long as he was on the rehab program.

And, in fact, in the fall of 2016, I believe it was, we topped that up to 90 percent. So he would have been in receipt of 90 percent of his salary ongoing until he finished the program and theoretically was engaged in employment outside of CAF and/or he would have been deemed diminished earnings capacity allowance and could potentially receive those earning loss payments until he turned 65. So the financial component, although it wasn't being paid by VAC, as long as he was on the rehab program once he finished SISIP, he could apply for those

financial benefits.

Q. We've heard that ... from other witnesses that financial stress was a major stressor for Cpl. Desmond and, in fact, prior to going to Ste. Anne's, he had reported that he was going to a food bank, had no gas money to attend appointments, and was planning to file for bankruptcy. This was before he sold his home in New Brunswick. You would agree, I guess, that that would be a concern for Veterans Affairs or the military, anybody dealing with Cpl. Desmond?

A. Yeah. Certainly ... that's why the intent of the program is to guarantee a minimum of 75 percent of income and today it's 90 percent. So I'm not sure what his particular situation is. I haven't reviewed the file. But, certainly, while he was on rehab, he should have been guaranteed at least 75 percent of his pre-release salary.

Q. Thank you, Mr. Marshall. Now, Mr. Marshall, it's not uncommon for a veteran to move ... or to live some distance away from an OSI clinic. There's a limited number of OSI clinics. That's a fair comment?

A. I think today, the last I read, is we have something like 11 OSI clinics and potentially some satellite clinics. And I believe that continues to expand. But, certainly, there are

limitations in terms of locations, yes.

Q. So in terms of those veterans, it wouldn't be an uncommon experience for a case manager or Veterans Affairs ... whoever from Veterans Affairs to attempt to be setting up services outside of an OSI clinic for a discharged veteran to find private providers.

A. Yeah. That wouldn't be uncommon to work with the veteran to identify private providers in their community.

Q. Now in this case, Cpl. Desmond returned from the Ste. Anne's clinic. He had been living near Gagetown and then was planning to move back to his home in Nova Scotia. Again, not a terribly uncommon scenario, I can imagine, for a veteran to move to a new location upon being discharged?

A. It's not uncommon for somebody to ... and, certainly, they're entitled to a last move. So it's not uncommon for releasing members to move, say, back to their hometown or to pursue work elsewhere as well.

Q. And in that case where there's a move that's either planned or known in advance, would that make it easier to set up those private services in a non-OSI area, if I can term it that way?

A. Right. So you have a couple of options there,

depending on the location, whether or not there are any resources. And, you know, in my particular area, we have locations where, you know, it's a large distance between the local provider ... people have to drive a couple of hours to, say, access psychological services. Rural Newfoundland is a good example. A lot of our veterans have to drive, say, from the northern peninsula to Corner Brook or somewhere like that to receive services.

The other option, of course, is these OSI clinics provide telemental health. So if someone were transitioning, you may continue to engage OSI services through telemental health if there wasn't one locally or if it was impractical for the client to attend inpatient treatment. And I should just add ...

Q. Go ahead.

A. ... that we would also cover health-related travel. If someone decided that say, for example, they were going to continue to attend the OSI clinic but it was a two-hour drive or whatever, as we explained earlier ... and I think this veteran did take advantage of health-related travel. So we may compensate them for their travel to attend that treatment say ... particularly if it was a long drive. They'd be covered for meals and those types of things.

LEE MARSHALL, Cross-Examination by Mr. Rodgers

Q. Thinking of the health records, Mr. Marshall, you mentioned earlier that ... I believe you said that veterans are encouraged to ask for a copy of their records upon discharge when they're being released. Wouldn't it make as much sense to just give it to them regardless of whether they asked?

A. I couldn't speak to DND policy or CAF policy on that. You know, if I wanted access to my ... as an example, my physician doesn't share my records with me but certainly if I wanted a copy of those records, I'm sure I could request it. In terms of what DND's practices are and why, I wouldn't want to ... I'm no expert in that area.

Q. Okay. When it comes to a case manager, a veteran that has a case manager assisting them, what is it that prevents a case manager from sharing the health records of a veteran under their care with a hospital or a health provider?

A. So ...

Q. So I think if I heard you correctly ... sorry to interrupt. Maybe I'll ask the question in a slightly different way, which is if I understand your answer earlier, the case managers would have access to some of those records, if not most of those records ... health records, that is?

A. So service health records today ... if a client

applies for a disability award or a pain and suffering compensation, service health care records can be downloaded into CSDN. But our case managers are actually instructed that they are not to access those documents because there's not a need to know. And we only access information where we have a need to know. So a case manager would only access any personal records of a veteran, say, if they had a need to do so. So most case managers would not be accessing medical service records.

Q. Would they ...

A. In terms of sharing records ...

Q. Yes.

A. Oh, sorry. Go ahead.

Q. No. Go ahead. Finish off there what you were saying. You were getting into what I was going to ask.

A. Okay. So you had mentioned about provincial health authorities, et cetera. So if the veteran made request for those records to be shared, it would unlikely be requested to the case manager. It would more likely be requested to DND, who would have the original copy of those records because the case manager would not have a need to access those records and, therefore, would not have control of those records. But I'm confident that there are processes where a veteran could make

requests for records to be shared from one federal department to a provincial health authority, theoretically.

Q. Well, that sounds complicated. What about a veteran who's having head injuries and having difficulty with cognitive issues? Wouldn't it be just as easy for the case manager to access those records and provide those to the hospital or family doctor that the veteran has ... to whom the veteran has been assigned and, there, the veteran can show up at the doctor and everything has been taken care of for them?

A. So we don't have a legal right to access those documents as case managers, typically. So it would not be a normal practice for us to access them. It certainly wouldn't be a practice for us to share those documents with another health provider without very explicit direction from a veteran.

Q. Yes.

A. Because keep in mind we're also protecting the veteran's information here and their rights to privacy. And so, again, while VAC may not directly provide the records, potentially a VAC agent, case manager, or VSA, or perhaps we could engage a clinical care manager to work with a veteran to request access to those documents to have them shared, say, with their GP.

(16:00)

There's no ... we don't know what information is in those records and it's not our right to access, to look. It's not our right to share those unless, again, very explicit directions from the veteran. And so I would tell the veteran to go to source and we would support them in going to source for the information.

Q. If I'm hearing correctly, Mr. Marshall, it seems that it might be more of a privacy/legal issue rather than a practical technology issue. In other words, the case manager or the clinical care worker ... well, the case manager would be able to access the records if permission was granted.

A. So the case manager would be able to if permission was granted and, really, they had a direct need to know. So we're very schooled in accessing the information only if we need to know. So while I may have files that, theoretically, I could go in and access, I don't do that because I don't have an explicit business need to know to access that information. So that's part of it. And, certainly, then, the protection of privacy and information of the veteran is the second component to that so ...

Q. A similar kind of question. Has Veterans Affairs

considered a policy of informing local mental health providers, hospitals, when a veteran has moved to the area, or particularly where a veteran who is actively engaged in mental health treatment has moved to the area?

A. No, I think there'd be some serious consequences on privacy there. We may help a veteran engage in community resources but, as I mentioned earlier, most of our veterans access private resources or resources through the OSI clinic because provincial resources often have wait times and may not be as accessible for a veteran who has a treatment through us who can access private care. I hope that makes sense.

But in terms of some sort of registry for veterans with mental health issues that would be shared provincially, no, we don't do anything of that nature.

Q. What about in terms, more broadly, in terms of sharing either research, education opportunities, continuing education, with private mental health providers or with provincial mental health providers? Is that something in which Veterans Affairs is actively engaged?

A. Absolutely. Depending on the local office, we develop relationships with local providers, even the health authorities, and share general information about veterans. It's really

dependent on what's happening in the local area, so I can't say, speak, to Nova Scotia, but we've had meetings with provincial health authorities, explained to them what VAC benefits are out there, encouraged them to refer to VAC.

For example, in the homeless initiative, we've developed posters to put in places like shelters, et cetera, where veterans might be, or people who support veterans might be, that explains how to access VAC and who should access it. So we do do that kind of work - we refer to it as "outreach" on a fairly regular basis.

Q. Right. I want to switch a little bit here, Mr. Marshall, and ask you about case workers. And you've already been asked about cultural competency training, so we have your answer there, but what about in terms of the case workers themselves? Would you be able to give us a sense of how many Veterans Affairs case workers in Nova Scotia or in the Maritimes or Atlantic region are of African Nova Scotian descent or is diversity among the case workers something that is tracked or considered?

A. So I wouldn't be able to speak to Nova Scotia. Certainly, employment equity and diversity is a fundamental part of the Government of Canada's agenda, and so I know we set

targets and try to engage, you know, minority populations, et cetera, for a diverse public service. In terms of data around Nova Scotia, I'm sorry, I wouldn't have that information.

Q. What about former soldiers working as case workers, you know, in order to use the logistical and institutional knowledge that a former soldier may bring with them or provide motivated workers to the system while still helping the soldier that may transition into a new career as a case worker? Are there examples, or many examples, of that taking place?

A. So we have the **Veterans Hiring Act** and so we do regularly engage and hire veterans. They would still, of course, have to meet the competencies of whatever position they're applying for. So I think I explained earlier that the case manager position, specifically, requires lots of case management experience and, typically, are people of social work or nursing or occupational therapy backgrounds. Certainly, there are former CAF members in those positions, but we regularly recruit veterans. I have multiple veterans on my team, on my management team.

Also, our Department, in light of what we do, attracts a lot of family members of veterans. And so if you walk through any office, you're going to find a multitude of people that are

either married to veterans, are veterans themselves, or their father or child is a serving member. So it's very much a focus of the Department to enhance the number of veterans and former CAF members working within our ranks.

Q. It would certainly seem sensible that former warrant officers, for example, would make good case managers or coordinators of care. Would you ...

A. Again, it's based ... I mean I can't make or I'm not going to make a statement that a certain position within CAF would make a good case manager. They would have to meet the education requirements and then they would have to meet our experiential requirements. And, certainly, there are CAF members that do that but, in terms of general occupation, there's no general occupation really that I would apply, except for perhaps CAF case managers. They tend to be nurses and most of them could very easily meet the merit criteria for case managers. But our staffing process is really focussed on capacities and competencies because of the nature of the work. It's so complex, it's very challenging, and so it's very important for us to hire people who have that skill-set to be able to manage these types of very complex health, mental health-type situations. And so that's our focus. We hire based

on requirements and, certainly, we're encouraged to hire veterans where we can and we do.

Q. We've heard from Junior MacLellan who is a retired warrant officer and a family member of the Desmonds who did the bulk of the coordination and advocacy on behalf of the family after the tragedy in terms of logistics in coordinating and paying for funeral expenses. Can you tell us who or what kind of role would normally be assigned from Veterans Affairs to deal with that kind of an extraordinary situation, to come in after a tragedy and help the family with those kind of details and difficulties?

A. So it's dependent on who was working closely with the family often. So if a case manager was engaged with a family or a veteran and, post-death, they may be the contact, but it could also be a veteran service agent if they were working closely with the family. It's really situational.

Q. Okay.

A. But it is a factor that is considered after any passing of a veteran, particularly in this type of tragedy. Certainly, there would've been some discussion about the appropriate person to contact next of kin.

Q. In a situation where a veteran was either dissatisfied

or they didn't feel they were getting answers from a case manager, it's been suggested to me, or even without that situation, that the veterans that, like Cpl. Desmond, or even a member of his family, should've been able to pick up the phone and call the sergeant major at the JPSU for the Atlantic Region and have them come and help out, get in the car, visit the home, start to help him with coordination of services. Is that something that takes place? Is that an expectation through the JPSU or is that something you can speak to?

A. I can't speak to whether it's a policy or not. I am familiar with a situation similar where the JPSU staff did support a family post-death, I suppose, is the best way, but I don't know that it's part of their roles or responsibilities. That would be a question for CAF or Department of National Defence.

(16:10)

Q. And, sorry, I was thinking, actually, not post-death or post-tragedy, but prior to that when Cpl. Desmond felt he was facing a crisis. Would the JPSU still have been an outlet for him to contact? Or, again, you ... I take it from your answer that may be not something you can comment on but I'll ask anyway. Can you?

A. Yeah, I wouldn't comment on the JPSU staff but, certainly, VAC would've been, you know, the primary source of support post-release.

Q. One of the documents that's been provided to us is a long counsellor manual, and I won't ask anybody to bring it up, but there's some good information in there. I don't know if you're familiar with this document, Mr. Marshall. It's for the EAP program for counsellors for the military and for the RCMP and it has very good, insightful information for family members talking about what it might be like for a veteran to come home, a soldier to come home, and the changes they might expect, the emotional changes that they might expect to see, and that sort of thing.

I guess my question is in that area. Is Veterans Affairs considering, or do they have, a systematic approach to that side of things, to involving the family, to providing the family members with information and guidance on what they can expect when a soldier comes home?

A. So I don't know that VAC specifically has a formalized approach. We had talked about mental health first aid. That's often coordinated through the MFRCs, and so that is very much what you discuss. It's a training session, talks about general

mental health, explains sort of impact of mental health, but it's geared towards CAF, and that's open to family members and those who support veterans. So that's one thing that certainly happened. And then we also talked about the online course that's available that can ... that veterans ... sorry, not veterans, veterans' families, can access. So it's online training around mental health. And so there are things available.

Funding, I'm not a hundred percent sure. My suspect is that funding is probably either CAF and DND, or a combination of VAC, CAF, and DND, but I know my staff sometimes participate in those training sessions as well.

Q. Certainly.

A. And that's also a big part of why I said that, you know, it's important for us to engage families in the conversations when we're meeting with veterans. And, certainly, it's not uncommon for VAC to pay for treatment-related, family-related couples counselling or psychoeducational training for family members who are supporting veterans who are coping with operational stress injuries.

Q. What about a more formal approach of getting families together in group settings or trying to establish, you know,

discussion forums or other relationships within, you know, among the family members of veterans? Is that something that Veterans Affairs does or is that something that you see taking place more informally?

A. I'm not a hundred percent certain that I understand what you're asking me but, certainly, as I said, like the mental health first aid tends to be family members attending in a group setting and receiving training and having discussions. I'm sure there are other support networks in place. Certainly, the MFRC would be a major support to serving members and, as I had indicated before, veterans are also entitled to support from military family resource centres, and that is a very concrete sort of service to support members and family members of serving members or veterans now.

Q. Switch again, Mr. Marshall. Just a few more topics to cover here. One is the OSI or, sorry, the Ste. Anne's clinic, the residential treatment facility, and one of the things we heard was that there was a ... and I think we'll probably hear more on this, but there was an urgent referral made in December 2015 and then Cpl. Desmond didn't get in until May of 2016. Now there were some discussions, and he may have been responsible for some of that timeline, but we also heard that there's only

ten beds in that facility, and it's a national program. I guess, from your position, the question is do you see a need for more of those type of facilities based on the demand that exists?

A. So there are a lot of inpatient facilities that VAC accesses regularly across country. Certainly, Ste. Anne's is one, but there are multiple inpatient treatment programs that VAC refers clients to on a regular and ongoing basis. What I understand of these programs is that case managers and/or local psychologists, or whoever is treating the veteran, will try to identify a program that best suits the needs of that individual. Some of them focus a lot on addictions, some of them focus more on, you know, particular conditions. So they're all very specific. I don't have a list that I can refer to for you but we do access multiple inpatient treatment facilities.

Sometimes there's time delays related to getting the required information for the facility so they know who they have coming and whether it's an appropriate referral. There are also requirements at different facilities. Some of them, you have to be off certain medications before you attend. For example, medical marijuana or cannabis for medical purposes. You may not be able to take that when you're at the facility. And so,

sometimes, there's a period of preparation for veterans before they go into these facilities.

Q. Sure.

A. But there is a large network. Whether or not we need more, I'm not in a position to say yes or no, but I know we use them regularly, and I have not heard, really, that wait list is a huge issue. I know sometimes clients would like to get in sooner than they can but, again, most of them that we access are private providers, so I'm assuming that if there's a need, the market will meet the need and we'll see more open.

Q. What about in terms of facilities on the east coast? Here is a young guy from Nova Scotia and he's sent off to Montreal. Are you aware of facilities on the east coast or would you suggest that there's a need for such facilities on the east coast?

A. Yeah, I'm not specifically aware of what's on the east coast. I know there are provincial programs on the east coast and I'm aware of, without disclosing personal information, I'm aware that sometimes we've used those, in my experience, but whether or not there's a need to build a facility here, I couldn't tell you.

Q. When Cpl. Desmond left the Ste. Anne's facility, there

was a phone call that took place to review the recommendations of that facility, and the case worker was part of that conversation. Is that your understanding of how that should ... well, let me ... and then the written report wasn't provided for several months thereafter. Is that the common practice? Would, in your view, the better situation be for the written report to be available at that time or is this something that you deal with?

A. As the best practice, the written documentation, the sooner, the better, is preferred, but it is not uncommon to have a case discussion prior to receiving formalized documentation because sometimes the resources or recommendations in the final formalized documentation are referencing the case conferences. So we like to talk, as soon as possible, for obvious reasons, for preparing for the situation. So, you know, I'm no expert in that area other than it's not uncommon that we would have those conversations before we get formalized documentation.

Q. We saw the two different Regina Risk Indicator Tool measurements, one being ... suggesting that Cpl. Desmond had a moderate risk of an unsuccessful transition, and then the more recent one in 2016 suggesting that he had a high risk of an unsuccessful transition. In your view, could there be, or

should there be, authority for a VAC case manager to pause a release in those situations as a means to maintain the soldier in the VAC situation, something a little more controlled, rather than being released and discharged into the community? Is that something that you see or that you would advise or what issues would you identify there?

(16:20)

A. Well, so, technically, we're two separate departments, but, having said that, and so authorities around things like release dates isn't inherently in the delegation of a case manager but I, you know, I am aware that conversations can happen with respect to particular cases where the transition centre and the staff at the transition centre, which, at the time, was called a "JPSU" ... we refer to them as transition centres now. There are conversations and discussions that occur where releases could potentially be delayed for that purpose. And that's sort of bridging that gap so VAC and CAF are working together. So it's not necessarily needs to be a VAC authority but, certainly, the conversation about a particular case, it's good to have that conversation prior to release to make a determination on whether release is not only appropriate or not, you also have to consider what the veteran wants, and sometimes

veterans or releasing members want to get out ASAP because they have plans they've made and want to move forward with those plans.

Q. Right. Mr. Marshall, changing topics again, I'm wondering if you're familiar with Dr. Paul Smith, a physician in New Brunswick that treats some members out of Gagetown, and he's developed ... he's done some research and he's developed a model which I referred to, I think, as the new legion model, of a gathering place for discharged members who have PTSD that are able to gather, hang out with one another. There's medical cannabis involved, those with prescriptions can consume, and they do nature retreats, that sort of thing. Is this something that you're aware of?

A. No, I'm not familiar with that at all. I've heard the name but I'm not familiar about that proposal or what it entails, sorry.

Q. Dr. Smith described that he had, you know, more experienced veterans that were acting as coaches, in a way, or mentors for the newer veterans, and they provided social support and structure. Are you aware of whether it's Dr. Smith's model, in particular, or that concept, generally, is Veterans Affairs looking at this, studying this, can you tell us?

A. So VAC has a grant program to support research in support of veterans and, you know, if someone approached me with a plan or a proposal of something like that, I would reference that grant program, whose name escapes me right now, but, in terms of those proposals, those kind of grassroot-type developments, you know, it's certainly not in my role to say whether one is better than the other or whether it should be funded or organized.

What I do know is veterans often find themselves, or identify, with other groups. And there are a multitude of veterans groups out there for social and/or other purposes. Formally, here, with us, I mean we have the peer support group and I know they do some group sessions as well. That's specifically for folks with operational stress injuries. That's what I could say about that. Not familiar with his proposal or that model whatsoever, but I would refer anyone who has an idea like that to apply for our grant program.

Q. Thank you. Mr. Marshall, those are all the questions I had for you today. Thank you very much.

A. Okay, thank you.

THE COURT: Mr. Rodgers.

MR. RODGERS: Thank you, Your Honour.

THE COURT: Mr. MacKenzie?

CROSS-EXAMINATION BY MR. MACKENZIE

(16:25)

MR. MACKENZIE: Good afternoon, Mr. Marshall. My name is ...

A. Good afternoon.

Q. ... Daniel MacKenzie. I'm here on behalf of the Nova Scotia Health Authority. You can hear me okay?

A. I can hear you fine, yeah.

Q. Great. I just have ...

A. You can hear me, I assume?

Q. Yes, I can. I just have a couple of questions for you this afternoon and they're mostly in relation to access to documents. I know you've already spoken about that, but I just have a couple of questions about VAC's involvement in that process, if any, okay?

A. Okay.

Q. So I understand what you're saying about VAC not holding the medical records. They may be elsewhere, with DND or CAF, but if a veteran wants to access their records and doesn't know where to find them, they can call up their case manager who

could then help them navigate those forms, correct?

A. Yes, absolutely. And, in fact, they could call the NCCN and potentially get that support about how to access their information. So we have, as I explained earlier, a multitude of layers of support based on what's required and so, yes, absolutely. We get phone calls like that fairly regularly.

Q. Right. And you mentioned that the NCCNs, they have, you know, kind of rehearsed answers to some of these questions, right?

A. That is correct.

Q. And so one of those questions could be, Hey, where do I find my documents? And they could say, Look, here's the consent form for CAF records, here's the consent form for access to DND records and VAC records and so on and so forth, right?

A. Yeah. I can't speak to if that exists but, certainly, it's probable that it does.

Q. So if a veteran doesn't know where to go to get these documents and a psychiatrist says, Hey, I'd like to see your medical records from your time in the Forces, they can call up either their case manager or the NCCN and get those answers.

A. Yes.

Q. Yes, okay. And those consent forms, you're familiar

with them?

A. When you say "those consent forms", are you talking about ATIP forms or release of information forms?

Q. Yeah. So consent for Veterans Affairs to disclose personal information to third parties. Are you familiar with that form?

A. Right. Yes, I am somewhat familiar.

Q. Okay. And so those forms, they call for certain pieces of information that a doctor might not have, right?

A. Potentially, yes. Depending on what the request is, yeah.

Q. Right. And so the doctor or the hospital, they don't have the service number for that particular veteran, right?

A. I really don't know what they have and don't have but it's certainly probable that they wouldn't hold the service number for a veteran unless he disclosed it, I guess, and asked them to put it on their file.

Q. Right. So the veteran might know their service number and could tell that to somebody who is trying to help them fill out these forms. Is that right?

A. Yes. Yeah.

Q. Okay.

A. That is correct, yeah.

Q. And if a veteran doesn't know his service number, he could call up the case manager or the NCCN number and get that?

A. I've never met a veteran who didn't know their service number.

Q. Fair enough.

A. But I guess it's plausible that they could access that information.

Q. Okay. And the forms also call for a CSDN ID number. I guess that's the client service delivery network ID number?

A. Yes.

Q. Okay.

A. Yes. It's a number assigned to him through CSDN.

Q. Okay. And the veteran may not know their ID number off heart?

A. It's highly unlikely that they would, but when they call us, if they wanted to know that number, that's something we could provide for them, yes.

Q. That's something they could provide to help them fill out these forms and get these consents finalized. That's correct?

A. Yes.

Q. Sorry, I didn't really phrase it as a question, but ... okay. Okay, no, those are my questions. Thank you very much.

A. You're welcome.

THE COURT: Ms. MacGregor?

MS. MACGREGOR: No questions, Your Honour.

THE COURT: Thank you. Ms. Ward, do you have any follow-up with your witness?

MS. WARD: No, Your Honour.

THE COURT: Thank you. Mr. Murray?

MR. MURRAY: No, Your Honour.

EXAMINATION BY THE COURT

(16:30)

THE COURT: Okay.

Mr. Marshall, I just have a couple of questions and I'm going to try and be as focussed as counsel were. There was a discussion that was related to access to health records by the case manager and you said that even if you had a consent from the veteran to access the medical records in CAF, even if you had the consent, that you still had to have a need-to-know reason the case manager would still require. So you'd require

two things to be able to access them, even with the consent or the request of the veteran. Would that be correct?

A. Yes.

Q. Or would the request of the veteran, because he or she or they say, Look, I need access to these records because I was in the emergency department of the St. Martha's Hospital on October the 26th and I'm seeing a psychiatrist in November, I want to be able to get him or her or them to have access to my records, I need a copy of them, can you punch them up and print them out for me so I can take them to see my doctor. Considering that now that it's now in the best interest of the veteran, it's part of his mental health rehabilitation, even if he's conducting it on his own, to have those in his hands so he takes them to his psychiatrist, wouldn't be a need-to-know good enough reason to assist him?

A. So I can tell you that if a veteran comes into our office and says, you know, I have a new psychologist, he wants to see the last assessment that was completed on me, could you print that off for me. Now we have a need-to-know because a veteran has requested it and, obviously, we have consent and so, therefore, potentially, we could go in and print that document and provide it to the veteran. We'll often review it to make

sure that there's no information belonging to somebody else, say, reference to another individual or whatever and we would have to redact that information. Also want to ensure that there's no harm that could be caused by releasing that document and I suppose if there was some, you know, scathing remarks from a psychologist in the report that may have a negative impact on someone with a fragile emotional state, we may consider that. But, in those cases, yes, assuming those things are in line, we could provide that information.

The question around service health care records is a little above my understanding and pay grade, truthfully, about whether a case manager could go in and access those service health records. But, theoretically, we would have never have accessed them before and we are not aware of what information is in those service records. And there could be information in those service records that the veteran may not necessarily want shared. There may be information in those service records that belong to other people. An accident occurred and there was more than one individual involved and their information is in that report.

The bottom line is, without my full knowledge of what's in those documents, I would advise my case manager not to share

that document and to request, a formal request that a copy of that file through ATIP. That's the process today. Whether that can be improved, sir, certainly is open for discussion at a higher level, I guess. But we try to provide information that's useful to the veteran as much as possible, particularly with their consent.

Q. So health care documents that are in your possession, if the veteran makes a request of the documents you can access. So, for instance, I'll make it more specific. In this particular case, we know that Cpl. Desmond was at St. Anne's Hospital. When he left, there was a discharge summary that was prepared and, from the documentation, I know that that found its way into the case manager's hands, into the file. And, at some point, I read a document that Cpl. Desmond had made a phone call and was requesting a copy of the discharge summary from Ste. Anne's. Now that would be a document which I assume the case manager could have printed off and given to him or forwarded to the health care person that he may have wanted it to go to. Would that be correct?

A. Yeah, there would be a couple of options there. If I had access to that document, then I reviewed it in the same light as I reviewed ... as I talked about reviewing, you know,

another site document where there was no other information in there, it wasn't going to upset the client, then theoretically I might be able to release that to him. Given I've never been in that position, I may actually, while the veteran is there, call my ATIP coordinator and just verify that that's kosher to do that. But it's in line with what I said to you previously, particularly if we paid for an assessment and we may be the only people who have access to that assessment, then it would potentially be plausible for me to provide that document.

Sometimes the requests are much larger and the amount of information is much more than, say, we could have an area counsellor or, sorry, a case manager go in and review and redact and perform all those activities, because that would be time away from serving clients. So we might say, well, that's a lot of information. I'd recommend you make a formal ATIP request.

Q. Well, one of the things about the discharge, they are summaries and they capture a lot of information which I would suggest would give an attending psychiatrist or psychologist, or even a general practitioner, some idea of, in this particular case, where Cpl. Desmond had been and what he was going through and what they had anticipated might be required in the future by way of treatment for him. I know it, I've read it, you haven't,

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so I won't ask you to respond to it as a question.

A. Okay.

THE COURT: Thank you, Mr. Marshall. I think we're done for the day. We certainly appreciate you appearing today and the time that you've taken to inform yourself with respect to these matters and provide us with details. It's been very helpful to me, I know, and I think it has been to counsel.

Once again, thank you, Mr. Marshall, for your time. We very much appreciate it. Have a good day.

MR. MARSHALL: Thank you, I appreciate it. Good luck.

THE COURT: Thank you very much.

MR. MARSHALL: I'll just sign out, Your Honour?

THE COURT: We'll sign you out in a minute. Thank you.

WITNESS WITHDREW (16:37 hrs.)

THE COURT: So Mr. Marshall is signed out. Before we leave, I wanted to have a discussion about some matters.

Ms. Ward, I understand that ... Let me, just before I call you. Just let me back up a little bit here. When we adjourned some time ago, and we had anticipated returning yesterday to hear Mr. Marshall's evidence and then the anticipation was that we would hear from Mr. Desmond's case manager, Ms. Doucette, on today's date. There was some rescheduling. I rescheduled the

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matter and I did it in part because of some information that had become available to the Inquiry. My understanding is that Ms. Ward and Ms. Grant, in preparation for the evidence of Ms. Doucette, realized that there had been some documents prepared by Ms. Doucette that related to an internal review and the notes were subsequently sent to Inquiry Counsel. I think that was on April the 11th, in the mid evening of April 11th. On the 13th, I had access to the email and, when I read the email and I read the documents, it occurred to me and in discussions with Inquiry Counsel that some more time was going to be required to review the notes and some of the context that was referenced in those notes of Ms. Doucette before she testified. I just assumed that counsel would likely appreciate some more time because I sent that email on the 14th advising and sending a copy of those notes. And I think I also advised at that time that there was going to be a change in schedule because of that disclosure so there would be more time to review. Whether counsel required more time to review or not really wasn't the driving force. It was because I needed more time to review it. I have enough things going on in relation to the Inquiry that when that kind of work comes to my desk, it requires that I spent some time looking at it. And so even if counsel didn't require more time,

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I certainly did and that's why I made the decision to adjourn Ms. Doucette's evidence. I appreciate that Ms. Doucette is anxious to testify. I appreciate that the delay is difficult on Ms. Doucette and it will not be a long delay. We will work at trying to find the earliest possible dates that Ms. Doucette can, in fact, testify. It's just one of those things that arises when the notes become aware. Ms. Ward and Ms. Grant provided them to Inquiry Counsel, as they should have, and that process unfolded exactly the way I would expect it should have. So that it causes a short delay is not unusual.

(16:40)

In the email, subsequent email, emails that were sent, there was another issue that arose with respect to the question of, I'm going to call them informal reviews following the January 3rd events and these informal reviews by CAF and Veterans Affairs Canada. And that there are either notes or review and perhaps some reasons or recommendations, and I don't know what label exactly to put on it because I've not seen it. And Ms. Ward, in correspondence to Mr. Allen and Mr. Russell, expressed the view that the documentation may have specifically written to request confirmation whether or not it existed or not, but took the view with respect to it being irrelevant and,

therefore, not disclosable. I understand that that ... And I will say this, that the parties that have documents can review their own documents and they make a decision about their documents themselves. If you think a document needs to be edited, you edit it. If you think it's privileged, you declare it's privileged but you also disclose that it exists and if it needs to be edited and there are well-established procedures for dealing with redactions and disclosure and deciding issues of relevance. But those are all decided here.

The document, when we learn it exists, but that's not the end of the process, but it really is the state of a beginning of a process for determination as to whether or not it's going to be disclosed and the manner in which it will be disclosed and to allow counsel an opportunity to put their positions forward. That was the purpose of sending the email to counsel with the body of the email that counsel had sent to Inquiry Counsel. So you would see exactly the rationale. Those words, not filtered or re-expressed by me, but I wanted you to see the words that were there so that there would be no misunderstanding as to what was said.

That email was not expected to be a launching pad for criticism but rather simply as a vehicle to inform counsel that

there was new information that existed. I had previously sent emails to counsel with regard to how they were to treat information that came by way of planning and such other matters and how they were to be treated in terms of confidentiality until they were dealt with in here.

I was disappointed today to wake up to a broadcast listening to matters being discussed about the Inquiry and documents before I had even had a chance to address them with counsel in this room. I do not want to see that happen again and, if I cannot be confident in counsel's ability to keep matters confidential, I'll simply cut counsel off from them. It's that simple.

Ms. Ward, I understand with regard to the documents relating to the review, I'll deal with Veterans Affairs Canada, can you give me your position on those documents today, please?

MS. WARD: The document has been provided to Inquiry Counsel. We're still of the view that it's covered by jurisdictional immunity and outside the terms of reference but we leave that determination to Your Honour.

THE COURT: Thank you. I'll review the document and I'll make that decision, the same way I did with regard to the documents that had been edited for relevance. When I've had an

opportunity to do that, if I find it necessary to have a discussion with counsel *in camera* with regard to anything that might be in those documents or anything in particular, then that's the process that's set out. The documents will be reviewed and I'll get back to Counsel in relation to them.

The process that Ms. Ward and Ms. Grant undertook to inform counsel and to state their position was, in fact, something that they were entitled to do in the manner in which they did it, they were entitled to do. And addressing it today in here and addressing it to me is what they're entitled to do and the way it's expected to be done, not outside the walls of this room. I see nothing wrong with the approach that they have taken. They're entitled to take instructions and proceed as they did.

We're adjourned for the day.

What time are we starting tomorrow, Mr. Russell?

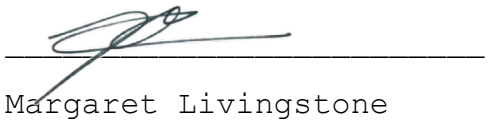
MR. RUSSELL: 9:30, Your Honour.

THE COURT: 9:30. Thank you, Counsel, see you back here at 9:30 tomorrow morning.

COURT CLOSED (16:47 hrs.)

CERTIFICATE OF COURT TRANSCRIBER

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



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