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: February, 24, 2021

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

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

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

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

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

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

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

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

INDEX

EXHIBIT LIST

EXHIBIT LIST

FEBRUARY 24, 2021

COURT OPENED (09:29 HRS)

THE COURT: Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Good morning, Dr. Rogers.

DR. ROGERS: Good morning.

THE COURT: Dr. Rogers, just before Mr. Murray asks you some questions, we're going to make arrangements to have you sworn as a witness on the Inquiry. Ms. Acker is going to ask you, give you some options as to how to be sworn.

DR. ROGERS: Okay.

DR. WENDY ROGERS, affirmed, testified:

THE COURT: Mr. Murray?

MR. MURRAY: Thank you, Your Honour.

DIRECT EXAMINATION

MR. MURRAY: Good morning, Dr. Rogers.

A. Good morning.

Q. Are you able to hear me okay?

A. Yes, very well, thanks.

Q. Okay, great. If anywhere along the way, you have trouble hearing me, just wave or shout or tell me to repeat the question.

A. Okay.

Q. Okay? All right, great.

A. Sure.

Q. Dr. Rogers, can you tell the Inquiry your full name, please?

A. It's Wendy Laurel Rogers.

Q. Thank you. And Dr. Rogers, how are you employed?

A. Right now, I am a part-time, self-employed in private

practice.

Q. And that's as a psychologist, is it?

A. Yes, a clinical psychologist.

Q. All right. So I'm going to bring up your *CV*, which I think is marked as Exhibit 248, and just ask you some questions about the nature of your education and your work.

EXHIBIT P-000248 - *CURRICULUM VITAE* OF DR. WENDY ROGERS

A. Okay.

Q. I know you're familiar with it but we'll just wait for it to come up on the screen.

So Dr. Rogers, you are, as you said, a clinical psychologist and you received your PhD in clinical psychology in 1992 from McGill University? Is that correct?

A. That is correct, yeah.

Q. And you've worked as a clinical psychologist since that time have you?

A. Yes, I had some time periods where I wasn't working clinically. For example, I worked at mental health central office for the Province of New Brunswick for two years, and when I was in Quebec, I worked really doing some program evaluation.

Q. Okay. And you've had an affiliation with the Canadian Armed Forces for now a significant period of time, have you?

A. Yes, that was my longest time I ever worked in one place other than private practice.

Q. Right. So your *CV* indicates that from September of 2006 to the present, you've worked as a clinical psychologist with Calian, is it?

A. Yes, Calian is a company that contracts to the Department of Defence and they're the ones that hire the psychologists, psychiatrists and some other professionals. I think dentists and pharmacists.

Q. Okay. And so through your employment with Calian and its contract with the Canadian Armed Forces, you've worked at the OTSSC which is the Operational Trauma and Stress Support Centre. Is that correct?

A. That's correct, yes.

Q. Okay. Can you tell us a little bit about the nature of your work with the OTSSC?

A. Yes. We did assessment and treatment of military members that had really any mental health condition; primarily, depression, but as time went on, more and more of my work was with members who had post-traumatic stress disorder. That became the majority of my work and the majority of my assessment, the majority of my treatment. And I also developed,

in conjunction with University of New Brunswick, an internship program so that we could train doctoral psychology students so that they would know how to treat military members.

Q. Are there unique challenges to treating military members with mental health difficulties?

A. There are some. I mean the main one might be the culture because the typical civilian doesn't really know how the military works, they don't know some of the ... I guess the, you know, the patriotism and the closeness of ... I guess the cohesion of the military members with each other and just the day-to-day challenges.

Q. Right.

A. And the other thing, it's a good ... you get very exposed to people who have more than one problem. Like, it's typical for post-traumatic stress disorder to occur along with depression. That's often part of it. And often substance abuse.

Q. Those are ...

A. So those are challenging too.

Q. Those particular conditions that you mentioned - post-traumatic stress disorder, depression, and substance abuse problems - are those, in your experience, particularly prevalent

among members of the Canadian Armed Forces or veterans?

A. Yes. I mean because a lot of them are young men and that's a typical age where people drink more than they do when they're older. And post-traumatic stress is not the most common disorder, but the OTSSC, that was their ... you know, a major purpose was to treat people who had combat-related PTSD.

Q. So during the time that you've worked with the OTSSC, I take it you've seen many members who have combat-related post-traumatic stress disorder?

A. Yes. Like, it ... you know, people always think of Afghanistan, and certainly that was prominent during the time I worked there but we had clients who came in with PTSD from tours in Rwanda and Bosnia and Africa and Haiti.

Q. Right. So it's not just related to Afghanistan. I appreciate that. Do you have a sense of, over the years, how many soldiers you may have seen who suffered from PTSD?

A. Well, certainly with assessments, I would have done a few hundred assessments, like, determining whether or not somebody had PTSD. And similarly, I would've seen a few hundred clients. I don't know the exact numbers because I don't have access to the database.

Q. Right. Over that period of time ... well, let me ask

you this. Do you have an area of specialty in psychology?

A. Yes. I mean clinical psychology for sure, but most of my training was to do with mood disorders, anxiety. And then before I worked at the base, I developed an interest in working with people who suffered from traumatic stress.

When I was in training, PTSD was considered something not common and the DSM-III-R was the diagnostic manual at the time. And they spoke as if PTSD was caused by events outside the normal human experience, and that proves not to be true because in addition to the military, who have many stressful events, you know, everyday things like car accidents and the kind of things that first responders experience, and childhood sexual and physical abuse. So traumatic events are very common and so it's important to know how to treat people who develop PTSD.

Q. So has the thinking in the field of psychology and in subsequent DSM manuals, has it changed with respect to the diagnosis and treatment and cause of post-traumatic stress disorder?

A. Yes. I mean they no longer have that phrase about it being outside experience, so the criteria now are any direct exposure or witnessing of events that cause severe injury or death or exposure to details about horrific things, or any

sexual assault. And so the criteria have widened for the type of events that can lead to PTSD.

Q. So did you develop your interest in PTSD prior to beginning your work with the Canadian Armed Forces?

A. Yes. It was probably when I worked at the Dr. Everett Chalmers Hospital from 1997 to 2002 and I began to encounter, you know, many patients who'd experienced very stressful events and were reacting to them even years later. And they did not all have PTSD but some of them did.

(09:40)

Q. Right.

A. And so I started attending workshops and doing more reading.

Q. So you are an adult psychologist. Is that correct?

A. That's right. I haven't treated children since my internship in 1988, so I'm no longer qualified to work with kids.

Q. So beyond being an adult psychologist, is there a formal subspecialty in the area of psychology or is an adult psychologist able to treat any of the conditions that you've mentioned earlier?

A. Oh, in New Brunswick, they ... you know, you try to

treat general conditions, but there's lots of things I do not have expertise in. Things like learning disabilities or ADHD or autism. And so it's mainly mood and anxiety disorders and people who have disregulated emotions and post-traumatic stress. So that became my specialty over the last 15 years, I guess.

Q. All right. So just following up on your work experience, you had mentioned that you worked at the Dr. Everett Chalmers Regional Hospital from '97 to '02. You started with Calian and their contract with the Canadian Armed Forces in 2006. And from 2013 to the present, you were the program leader for the OTSSC?

A. I was for a few years. I think it was, oh, probably 2013 maybe until 2017.

Q. Okay. And what were your responsibilities as program leader at the OTSSC?

A. Mainly, like, what I mainly did is I wanted to make sure that, as much as possible, we were all trained in the evidence-based treatment. So one of the things I arranged for, I think we were the first military base in Canada that had training in cognitive processing therapy and we started that in 2010. So that was actually before, but ... so things like that and beginning the internship program with UNB, but otherwise,

the reason I think those kind of positions were created at the OTSSCs was because the military personnel could often turn over every four years, so they wanted to have in place somebody that knew about the major treatments for post-traumatic stress.

Q. Okay. And I'm going to ask you about those in a moment, but just further looking at your *CV*, you said that you developed an expertise in post-traumatic stress and you've attended a number of workshops, and I see, actually, in your *CV*, there are quite a number of workshops and continuing education sessions that you've attended on post-traumatic stress disorder?

A. Yes.

Q. Right. So Dr. Rogers, the OTSSC, can you give us a sense of, in that, what other professionals work there and how it may have expanded over the years that you've been there?

A. Yes. We started out, the mental health centre was quite small, and then when we had our first military psychiatrist, I think in 2009 or 2010, we became officially an OTSSC. And over the years, especially once people began coming back from Afghanistan, the staff increased quite a bit. Like before I worked there, there was one psychologist, now I believe they have five. And we have some excellent clinical social workers. We have nurses with specialty training in mental

health. We have three psychiatrists. And we also worked very closely with the general medical branch, so we were in touch with the medical officers who were physicians or nurse practitioners and then a physician assistant. So it was a real multidisciplinary approach to client care.

Q. Okay. So perhaps you can just give us a sense, when a member is referred to the OTSSC, first of all, how are they referred and what happens when they're referred?

A. Okay. The client would be referred from their medical officer because that's kind of the equivalent of our general practitioner in civilian life. So that's the person that is the first contact and kind of refers out for other care as needed. So if somebody came with troubling symptoms and the physician thought it was likely that they had a mental health condition, including PTSD, they would get referred for assessment at the mental health clinic. And so the mental health manager would arrange for that to happen. It could be a psychiatrist or it could be a psychologist who did the assessment. And then at the ... part of the assessment was making recommendations for treatment, and so the person would be assigned for whatever treatment was suitable.

In the OTSSC, we actually had a couple of things in

addition to the individual therapy. We had something called the OSEP group. That's occupational ... the operational stress education program. And it was just a four-session, small group intervention where we made sure that all the clients with a diagnosis of PTSD had a basic knowledge. Like what are the symptoms? A psychiatrist would come in and explain some of the medications used to manage symptoms. We talked about, a little bit about the types of treatment available, and at the end of each of the four sessions, we taught the client some kind of skill that would be useful in managing their symptoms. So anything from slow, deep breathing to something called grounding that helps someone cope when they're in distress.

So it was a good introduction. And after that they would be assigned to some kind of therapy. Usually individual, but sometimes group therapy and ...

Q. So the ... Just so I understand, when somebody comes in and it's determined they have a mental health problem, they would go that route. There's also a psychosocial route that somebody can go as well? Do I understand that correctly?

A. Yes. Like if it's a mental health diagnosis that the person has - so it would be something like a depressive disorder, PTSD or, you know, generalized anxiety, something like

that - they would come to mental health team, but if it was some stressful event in their life but not a mental health diagnosis, they would go to a psychosocial team. So it would be things like conflicts at work, harassment, parenting problems, marital problems, grief. Something that's troubling them and interfering with their function but is not a mental health disorder.

Q. Okay. And who would make that initial determination whether they should go the psychosocial route or the mental health route?

A. Well, I mean initially, the medical officer would refer to one or the other, but the mental health team leader, they could also decide, Oh no, this sounds more like it belongs to the other team. And we'd make that recommendation. And sometimes people have both. Like if somebody came in and was being treated for depression but they had marital problems, they could see somebody at psychosocial team as well.

Q. So if it's determined that a person primarily requires help from the mental health team, they would go that route. And then you said somebody would do an assessment of them, either a psychiatrist or a psychologist?

A. Yes.

Q. How would that be determined who would do the assessment?

A. Well, usually just by availability or if it was something like, if ADHD was a possibility, they'd refer to someone who had that expertise.

Q. Okay. And if a person, if a member, had, I guess, a tentative diagnosis or it was thought that they may be suffering from post-traumatic stress disorder, they would go the mental health route, I take it, would they?

(09:50)

A. Yes, definitely, yes.

Q. Okay. So the mental health team then, you said there would be psychiatrists, there would be psychologists, and more on the mental health side, what else would there be? What other professionals?

A. Oh, clinical social workers, and mental health nurses, and two addiction counsellors.

Q. Okay. So when a member has a potential diagnosis, I guess I'll say, of post-traumatic stress disorder, they come to the mental health side of the OTSSC and an assessment is done. Would a diagnosis be made typically right there? Would a professional say, Yes, I think this person has PTSD?

A. Yes. During the assessment, that would be ... we had a standardized assessment protocol, you know, it lists the certain ... you know, information and questions that we would ask, and if it seemed likely they had PTSD, we would ask in-depth about the PTSD symptoms and a psychologist would usually do some kind of psychometric test as well.

But in any case, we ask, you know, a wide variety of questions, like family background and medical history and legal history, screening for substance abuse, but really zeroing in on the symptoms that were prominent, whether they be depression or post-traumatic stress or something else.

Q. Okay. And then, I guess, following on from what you said, a person in that circumstance would then go to the OSEP, the OSEP group?

A. Yeah, they would be offered that. It wasn't obligatory. We didn't have that in the beginning, but once we had it, we wanted it to be kind of the standard way things were done. And the other thing that we offered to people in treatment for PTSD, if they had a spouse or a significant other, we would ask the client if we could invite that person to what we called a spousal group, and that was developed by one of the clinical social workers. It was an education and support group,

about six sessions, in the evening, and it was for spouses so they would understand PTSD and they would learn how to take care of their own needs instead of just focussing on their spouse.

Q. Did you find initially that there was a lack of awareness and understanding of what PTSD was?

A. Yes. Like, especially in some of the combat arms like infantry and artillery in the military. You know, they're really trained to suppress physical pain and emotional pain and keep on going, which is very adaptive for the kind of work they do. They have to be able to endure a lot, but it becomes difficult for them if they need treatment. They're used to giving the help, not asking for help. And so some of them, they have to learn how to figure out, okay, what ... how to label their emotions and how to cope with them.

Q. Right. And so the occupational stress education group, I take it one of its purposes, or main purposes, would be to help educate members and help them understand what may be going on with them?

A. Yes, in the small group format. It made ... it tended to reduce the shame because they would see that there were several other people in the room who were also soldiers and they were suffering the same type of problem, because there was a lot

of secrecy, like, in the beginning.

Certainly, many years ago, if you were diagnosed with PTSD, you would just be released from the military. And that has not been the case for many years, but people did not want to, and I think it's a pretty normal human tendency. We see it in civilians too. If they have ... if they're developing depression or anxiety, they try to cope on their own and they hope it will go away and they don't want to, you know, stop working for either financial reasons or they don't want to get out of the loop. And so people tend to just carry on until they cannot any longer. And there is a ... there was a stigma. Like, certainly, you know, they've come a long way, but some of the old guard in the past did not really believe in PTSD. Romeo Dallaire made a huge contribution that way because he was high-ranking, he openly admitted to it, and pushed for more treatment available.

Q. Right. And that culture then, you found, has changed over the years?

A. Yeah. People are more willing to come in for help.

Q. And the spouses' group you mentioned, I suppose a similar function to help spouses understand what's going on with their partners and how to deal with them?

A. Yes. And they even have one session on, you know, what kind of things to tell kids and how to help the kids cope.

Q. Okay.

A. And a lot of the spouses, they became so focussed on helping their partner that they stopped attending to their own needs, like, for friendship or leisure. And so the people were encouraged to not neglect themselves.

Q. In your experience, when a member is diagnosed with post-traumatic stress disorder and they have a partner, does that diagnosis and what it does to the member, does that put strain on the marriage or the relationship?

A. Oh yes. It's ... I mean some of the symptoms, like hypervigilance, where the person is always on guard and they don't really want to go out to public places and might stop wanting to socialize with friends just because they lose interest in things. It's quite common for those. And they'll ... some of them wake up in the night with a nightmare and their sleep is disturbed. Like, most people, when they're sleeping, they don't move. Their muscles are semiparalyzed during REM sleep. But there's a lot of sleep disturbances, so they'd have nightmares and they'd be sweating and thrashing around and it's very disturbing. The partner's sleep is disturbed. The person

might be really irritable and snap at the kids or snap at the wife or sometimes, you know, in extreme cases, I remember one man that he was so angry, he went out and completely trashed their shed. And so it's really hard. And then plus they feel distant from people. That's partly from PTSD. If they have some beliefs that the event was partly their fault or if they develop bitterness toward the military, they might just withdraw from people, including their own family. And so there's a lot of strains on the relationship.

Q. You had mentioned a moment ago that on the, I guess, psychosocial side, if I could say that, that there was some counselling for couples or in domestic situations? Did I understand that correctly?

A. Yes. Certainly, we could refer people for marital counselling, and over time, they developed some policies for what to do when you suspected violence. So then we had local provincial laws that if you were aware of a child being exposed to something dangerous, like someone 16 or under, you had to report it to the child services. But with the women too, the military had developed ways to help with that. And so we would not ignore it if we saw evidence.

Q. In your experience in treating members with PTSD, on

occasion, has domestic violence been a symptom, I guess, or an effect of a PTSD situation?

A. Not commonly. Like, I know that, you know, research has shown that it can be common in military populations, but I don't ... I didn't see a lot of that. Like some of the people would, they would feel very guilty if they did something like trashing the shed. They would feel very remorseful and ... but it was rare. I don't think I ever had a client who deliberately harmed a person. Usually, they're very conscious about taking out their anger on an object or leaving the house so that they would not fight with their wife or child but what remains is that irritability. It could be really hard to live with.

(10:00)

Q. Right. Okay, so if a member, it's determined, has combat-related PTSD and that diagnosis is made, then I assume a treatment plan would be worked out or there would be a determination about how to handle that member, is that correct?

A. Yes, because if it was post-traumatic stress we would recommend the OSEP group and we would recommend one of the ... you know, for them to have trauma-focussed therapy. And there's ... you know, in the military there was a policy that you had to provide evidence-based treatment, treatment that had a solid

research base that would be effective, yeah.

Q. Right, so I understand that for the treatment of PTSD there were three, or there are three, evidence-based forms of treatment, is that correct?

A. Yeah, the three major ones, and now there's some others that are coming into prominence as well, but yes, the three. Prolonged Exposure, I believe, is the one that has the most research. But there is one called Cognitive Processing Therapy. Again, it's probably 30-plus years of research. And they actually developed a specific manual for treating military-related PTSD. And then the third one is called EMDR, Eye Movement Desensitization Reprogramming. All three of them can be used successfully.

Q. Have you used all three forms of those treatments for PTSD?

A. Yes, I was first trained in Cognitive Processing Therapy, and the year after, I believe - 2011 - trained in Prolonged Exposure and then in spring of 2013 I received training in EMDR.

Q. So I'm going to ask you just a little bit about each of those just so that we understand them. Cognitive Processing Therapy, I understand, is a subset of Cognitive Behavioural

Therapy, is it?

A. Yes, it is. It uses those techniques, but what it does because it's a manualized treatment, it has a particular sequence and I found that made the treatment very ... much more efficient. Because, certainly, with the knowledge of Cognitive Behaviour Therapy you could address things like beliefs and behaviours and reduce anxiety. You could do a wide variety of things.

But the Cognitive Processing Therapy has a specific order of doing things. And you teach people. It really emphasizes how the event impacted a person's beliefs about themselves, about the event, about the world in general, and so it gives the person the tools to examine those beliefs and see if they are true. Because some of them are very damaging, and like, you know, beliefs such as, you know, I failed to do such and such and so it's my fault this happened, that can really destroy a person's self-esteem. So it's important to examine that belief and to see, Is it really true, and to what extent?

Q. So how in CPT how ... you said it's manualized and there's a structure to it. So there are a number of sessions that take a certain form, do they?

A. Yes. In the beginning the first session is

psychoeducation and then the second one, the person begins to learn how to label their ... the thoughts and the feelings they have in response to everyday events or the traumatic events. So they learn those tools, labelling emotions and knowing how they react to things. And they actually write about the impact the traumatic events have had on their lives.

So they talk about what they believe was the cause of the event and they talk about how the event shaped their beliefs in five areas. So a sense of safety, trust, power and control, intimacy, and esteem. And so the first few sessions are addressing beliefs about the event itself but all the while they're learning more tools to examine how they think and feel. And then the last five sessions are about those major areas.

Q. So they're asked to write their thoughts and feelings about the event in CPT, is that how it works?

A. Yes. They don't actually write about the event itself. In the early phases of CPT they did. That was part of the treatment in the middle of a therapy. They had to write in detail but research showed that that was not necessary. But if they focussed on the beliefs resulting from the event that worked equally well and people were more willing to do it.

Q. And they would write about these beliefs and then the

therapist does what, questions them about it or ...

A. Yeah, teaches them ... it really teach- ... you teach the person to become their own therapist. At first the therapist is more active, and so if they had a belief that, you know, such and such was all my fault, or, I was a bad person because I did this, we would just ask them questions and get them really thinking about things that they hadn't thought of before and ...

Q. They may have ... I think you said unhealthy or unproductive thoughts or feelings related to the trauma with such a self-blame?

A. Yes, yeah, and I've been trying to think of a ... like one example I recall is a client who had felt guilty for years. He had PTSD about a combat event and his belief was, I should have saved ... I should have been able to save them all. And so he just avoided thinking about it and distracted himself in many ways.

But when he actually did the treatment and he was learning how to challenge that belief he remembered that he could not have saved any of those four people because three of them were dead by the time he found them and the fourth one they needed some help from the Americans to get the person out of the

vehicle. So all these years he blamed himself, I'm a bad soldier, I should have saved them all and, in fact, he could not have saved any of them. So it's that kind of ... that kind of thing.

Q. Okay. And through doing this the patient challenges those unhelpful beliefs or may look at them differently? Is ... do I understand that correctly?

A. Yes, yeah, it's quite ... by the time they get to session six they've learned how to use something we call a challenging beliefs worksheet, and so by then they're able to label the emotions and the intensity of emotions attached to the problematic belief and then they're able to ask themselves the right kind of questions like, What evidence do you have, or, Is there something you've overlooked, or, Where did this belief come from?

And so they look at it in detail and they also look at their patterns of thinking. Because some people are worrywarts. They think the worst. A lot of people jump to conclusions or sometimes they do what we call mind-reading. They'll think, Oh, that ... you know, nobody likes me. But they have no evidence. It's just a feeling. So we get people to examine all those kind of things and then at the end they usually come to a different

conclusion.

So with self-blame they might think ... they might say, Oh, that was not my fault at all, these were the factors that caused the event. Or they might say, I had a part in it, but I did not intend the outcome, and would have a belief that caused less distress.

Q. And Cognitive Processing Therapy, is that done on an individual basis or is it in a group?

A. It can be done either way. The person who trained us in Cognitive Processing Therapy is Dr. Kate Chard, and she came and trained us in doing it in group therapy. And there you're harnessing the fact that other group members, they help challenge each other. So if someone is stuck on self-blame they're going to take a challenge from a buddy more easily than they might from one of the psychologists or social workers.

(10:10)

Q. Right. Okay. And have you found, when you've used it, Cognitive Processing Therapy to be helpful?

A. Yes. I mean the research shows it to be effective and I've seen some really good success with it. Like, what we do at the end, we get them to write another impact statement and it can be quite startling the difference in the beginning and the

end. In the beginning they might say it happened because, I forgot to do something and so now I, you know, I don't trust people and I don't feel safe. And then by the end they say, I realize now that this was not all my fault and that some people can be trusted and the world is not as dangerous as I thought it was. That's typically the kind of things people say.

Q. Okay. You said the second form of evidence-based trauma-focussed therapy that's used is Prolonged Exposure?

A. Yes.

Q. So ...

A. And I mean I ...

Q. Go ahead.

A. I guess what I should say is all three of the evidence-based things, they all do three things. They address avoidance. Because for years the person has avoided thinking about it, feeling ... having their feelings about the event, and they avoid situations that remind them of it. So all of the evidence-based therapies have a way of countering that avoidance by getting them to think about some aspect of the event and allowing them to just feel their natural feelings. Because you know, they're painful feelings. Sadness and disappointment and horror and fear and it's important to feel those feelings and

just let them come down on their own.

Prolonged Exposure takes a slightly different approach to that. It ... the person chooses to do repeated imaginal exposure to the event. So in the therapy session they would tell a story of their worst event and they would tell it often two or three times within the session. We record the sessions and then they can go home and they listen to it every night, and so they're no longer avoiding it.

And it's interesting. Sometimes we call it anticipatory anxiety, when you're anxious about something you haven't done yet and in your own mind you magnify it. You think, Oh, that would be horrible, I could not do it. And then they do it and they're distressed but it's not as bad as when they were in the event. And by telling and retelling, their level of distress begins to go down, and it's certainly ... it will go down over the next week or two as they listen to the recording.

And what happens is as the stress goes down, then the person is more able to use ... to think straight. And so they often ... like, say a woman recounting a rape might have believed in the beginning it was all her fault, but after she's recounted it and then listened to herself telling the story she thinks, Oh, no, that was not my fault, I said no, the guy had a

knife, I was ... he was stronger than I was, so no, it wasn't my fault. So they really reinterpret things differently.

And one of the things about listening to the recording of your own voice is it gives you a little bit of distance from the situation. So it's almost like you're listening to another person and so you have more empathy for yourself and you really see the wider array of factors that took place during the event.

Q. Okay, and ...

A. So that's one part. So the Prolonged Exposure, you have imaginal exposure in the therapy, but we also get them to do what we call *in vivo* exposure, which is going into situations that they've been avoiding. So commonly, it's being in public places or seeing certain military vehicles or hearing certain noises. Sometimes encountering smells. That's quite a challenging one. Things like the smell of diesel or the smell of rotting flesh, those are very difficult to overcome because, you know, some of those things are hardwired into us.

Q. Right, so ...

A. But in any case, we get them to stop avoiding situations that they need to go into.

Q. So typically, if you were treating a member using Prolonged Exposure would you start with the imaginal exposure

and work up to the *in vivo* exposure?

A. At some point you're doing them in parallel. Like, I think by session three or four you do them in parallel, and you know, some people ... I mean you have some flexibility there. Like, normally, you would do them in parallel but some people are less ready. But you get them started doing something small.

So, for example, if someone's afraid of going into big crowds you wouldn't start by sending them to a ... you know, a hockey game. Because it's very loud and lots of people. You would start them out maybe going to a neighbour's for coffee or going into a convenience store to buy a chocolate bar or something and then they gradually work their way up to no longer avoiding things that they have been avoiding.

Q. Okay. So for the imaginal exposure you say that the member will recount or retell the story or the event maybe two or three times and it will be recorded and then they go home and are expected ... or it's hoped that they'll listen to it multiple times between sessions?

A. Yes, yeah.

Q. Okay.

A. Yeah, and then during the session you monitor their distress level and you make sure that before they leave each

session that their distress level is down to a manageable amount.

Q. And are they given skills to use when they're listening or relistening to the recording of their event?

A. Yes. I mean in the ... I think the first session or second session of Prolonged Exposure they are taught to do the ... what the military calls tactical breathing, like the slow, deep, diaphragmatic breathing to give a person a tool to calm themselves down.

Q. Right.

A. But we don't emphasize that too much because we know that people are capable of feeling distress and not falling apart from it. Like, they often believe, Oh, if I talk about that event I won't be able to handle it. But they do.

Q. All right. And then the third form of evidence-based treatment is the EMDR?

A. Yes.

Q. And that's the ... help me out. Eye Movement Desensitization and ...

A. Desensitization Reprocessing.

Q. And Reprocessing. Thank you.

A. Yeah.

Q. And can you just give us a sense of what EMDR is all about?

A. Yeah. Nobody really knows how it works but it does. The person who developed it was Francine Shapiro, and just by some chance she discovered that if her eyes were moving back and forth while she remembered something distressing that she ... her distress levels went down, and she became curious about this and actually did her doctorate in clinical psychology and developed this method of therapy.

And it ... you know, it seems so strange when you have something that works and you don't know why. Psychologists are always curious and skeptical and they want to do research on it. They discovered that eye movements weren't necessary, that you could use alternative things. Like a client will hold two small things, one in each hand, and the machine delivers a small vibration first to one side, then the other.

So they believe it's bilateral stimulation that does something and some people compare it to REM sleep where your eyes are moving back and forth at a time when you consolidate your memories. But what they have found is having that stimulation, whether it's following the therapist's fingers, the eye movement side to side, or experiencing the vibration

alternatively in left and right hand, there's something about that that reduces the intensity of the imagery and so it makes clients more willing to do it.

(10:20)

They think about the worst part of the image and describe what they're feeling. They talk about all these sensations and they identify some belief about it like, I'm vulnerable or I'm a bad person. And then in 20 to 30-session stints they'll start thinking about the worst part of the event and they're silent while they receive the bilateral stimulation and then every 20 or 30 seconds the therapist will say, Well, what are you experiencing now? So they might be thinking about the event. They might say, Oh, my throat is all tight, I feel like it's hard to breathe. Or their mind might have jumped to something altogether different.

Like you don't really know what's going to happen, but there's sort of an algorithm for deciding how often to do this and when to switch to something else and when to get them to ... to rate their adaptive belief and the mal-adaptive belief. And it ... I think its strength is in how it helps people that have strong body sensations connect into the memory. It's very effective for that.

Q. And so the bilateral stimulation, you used your finger, is it often just having the person's eyes follow the therapist's finger?

A. Yes, and so that was a classic way. That was the way it was developed and then later they had other methods. They actually ... I think they have light bars where a light will flash alternatively on one side or the other. I've never used that. I've used the ... we call them the tappers, the one that delivers the vibration.

Q. Okay.

A. And I think they had ... they've experimented with audio tones, first to one ear, then the other, but that was found to be less effective than the others.

Q. Okay. So when a member is referred to you for treatment for PTSD is there a way in which you determine which of those three treatments is best suited to the member?

A. Yeah. Usually talk a little bit about each one, and if they have a strong preference that's what I would do. The Cognitive Processing Therapy requires a lot of written work in between sessions. A person would spend 15 to 30 minutes a day in written homework, and not everybody is willing to able to do that.

For example, I had a client who had two young kids and when he got home it was a bit chaotic. One of the kids had ADHD and he was a bit of a handful. And so expecting this man to go home after a day of work, have supper and he and his wife would get the kids ready for bed or help with homework if necessary. You know, you really don't want someone having to take on that and he wasn't willing. But he was willing to do one of the other methods. And EMDR, there's no homework in between sessions.

So we use client preference. We use practical considerations. Like, there were some patients who would not do Prolonged Exposure because they did not want to be recorded. Even though they were the one that had the recording and we would destroy ... if we had the machine we would destroy that at the end of treatment.

But ... so really, the client preference is important and then some military people, they might find the written work difficult. Like, some of the wording, they might find it too difficult, the wording of the questions. And so for them they would prefer something more hands-on.

Q. Right. Okay.

A. Yeah.

Q. So what I want to do, Dr. Rogers, is ask you a little

bit about your actual treatment and work with Lionel Desmond.

A. Okay.

Q. So you did work with Lionel Desmond and did treat him for post-traumatic stress disorder, did you?

A. I did, yes.

Q. Okay. So did he follow the route that you described earlier for a member being referred to the OTSSC?

A. Yes, he was referred and he was assessed by Dr. Joshi and then he attended the OSEP group and then he was assigned to me for individual therapy.

Q. Was there a particular reason, do you know, that he was assigned to you or was it just a function of your availability? **A.** Probably availability because there were several of us who had training in treatment of PTSD. So in those cases they would, yeah, refer the person to the next therapist who had the skills and who was available.

Q. Right. Okay. So we have in our materials a number of psychology progress notes and I'm going to start to refer to some of those. Those were documents that you would have completed as you were dealing with Lionel Desmond as a patient? Is that correct?

A. Yes, yeah.

EXHIBIT P-000232 - PSYCHOLOGY PROGRESS REPORT - DECEMBER 1, 2011

Q. So perhaps ... I think the first in time is marked as Exhibit 232. That's a psychology progress note from December 1st, 2011. So we'll just bring that up on the screen. I don't know if you have hard copies of the notes from ...

A. I ... no, I don't have printed copies. Now I cannot see the screen.

Q. Well, hopefully it'll come up there.

A. I mean I can see you but I can't see the note if you ...

Q. Okay.

A. Yeah, is it up on your screen?

Q. Yeah, it should be coming up on yours in a minute there.

A. Okay. Yeah.

Q. You can just let us know when you see it.

A. Okay.

Q. Any sign of it there yet?

A. No, no, I don't see it. But anyway, I mean if you talk about it I will probably remember it just because I have reviewed them.

THE COURT: Dr. Rogers, I'm advised that apparently

there are some technical difficulties on our end here, perhaps in Halifax, a bridging issue to get that document displayed so that you can actually see it. I think we'll maybe continue to ... Dr. Rogers made a suggestion that if you refer it'll refresh your memory to the events. If you have to read a portion of it I think, Mr. Murray, we'll try and proceed that way.

MR. MURRAY: Okay.

THE COURT: And Dr. Rogers, if it reaches a point where you really would like to have a look at a document just let us know and we may just have to take a pause and see if we can sort out how to get some of the documents that are most important to you.

A. Okay, and then one alternative I have is I could open up my copy of the document. I hadn't done that so far because I didn't want anything to interfere with the video transmission.

THE COURT: And I know exactly what you mean. When you start running too many things on your computers it may degrade something else when we need to have good audio and video.

A. Yes.

THE COURT: Let's see if Mr. Murray can refresh your memory sufficiently of the details by reading the portions to you before he asks you a question. As I said, if that's not

adequate we'll find another way to work around it. Thank you.

A. Okay.

MR. MURRAY: Thank you, Your Honour. Dr. Rogers, we love your clock.

A. Oh my goodness, I ... you know, we've had that thing for years and we don't even notice it. And I'm wearing headphones. So I don't hear it.

Q. No worries. Everybody likes it here. So let it go.

A. Oh, that's good.

THE COURT: Yeah, please don't be concerned about it. It's kind of refreshing actually.

A. Okay.

MR. MURRAY: So Dr. Rogers, the first of the psychology progress notes that we have in our materials are from December 1st, 2011. Do you recall if that would have been the first time that you would have seen Lionel Desmond?

(10:30)

A. Yes, I mean, he was in the OSEP group and I believe I was one of the people involved in that group, I'm not sure, but I think I was, but it was our first meeting one-on-one.

Q. Okay. So you may have been involved with him the OSEP group but this was the first kind of individual counselling that

you would have done with Lionel Desmond?

A. Yes. Yes.

Q. So prior to meeting with him, I take it you would know about his diagnosis that Dr. Joshi had done, that he had PTSD?

A. Yes, I would have read Dr. Joshi's assessment report and I don't have access to that document anymore, so I don't remember the details, but I certainly do know, you know, the questions he would have asked Lionel Desmond during his assessment, and I would have been aware of ... I would have been aware of the severity and have his diagnoses

Q. Okay. When we spoke to Dr. Joshi yesterday, one of the exhibits was a Psychiatry Assessment I think from late September of 2011. That would have been the document that you would have seen and read?

A. Yes. Yes.

Q. Would you have had access to any other documents related to Lionel Desmond before you met him?

A. Yes, we had been transitioning for a couple of years to the Canadian Health Information System and so that was actually a very useful system because we could see notes from the medical officers. We could see anything about their health treatment and we could see notes if they had seen someone at

psychosocial team, we could see the notes from medical stuff.

If we wanted to, we could have seen things like X-ray or surgery but we didn't really need to know that, but we could see anything we needed to know. Even if they had been at another base we could have seen the documents from there as well.

Q. How much background would you typically need to start doing individual therapy with a soldier with PTSD?

A. At the very minimum you would read the assessment and then you'd read some of the medical officer notes too, because you'd want to have fair sense of ... you'd want to know what trade they were in, what events they experienced, how severe their symptoms were, any general health conditions that would affect things. So, yeah, you could get as much or as little. Well, definitely the assessment would be a bare minimum but we looked at the other aspects of the file too.

Q. Okay. And apart from a medical history, when you meet with a soldier with PTSD for treatment, would you try to obtain other historical documents, their experience in combat, and so forth?

A. We typically wouldn't have access to those. We would have access to things like their pre-appointment screening or post-appointment screening, we'd have access to that. We would

know, you know, whether they had some condition like diabetes or high cholesterol, that would show up in the medical officer notes. We do not have access at all to anything like personnel files. Anything that was not medically-related we had no access to.

Q. And would you ask the member, though, about their experiences initially or would you kind of wait to do that?

A. No, we would ask and sometimes they would spontaneously talk about things. But in the first session you're really trying to get a general sense of the person, how severe are their symptoms, are they yet able to talk much about the event, and what their level of depression. Because in Lionel Desmond's case, he had quite marked depression, and often if the depression is very prominent you have to treat that before the PTSD. Not always, it's a bit of a judgment call, but you have to feel that they're ready and willing to do the trauma-focussed treatment first.

Q. Okay. And the document which we had marked as 232 said that your session, your initial session, was an hour. Is that about typical for a first session of this nature?

A. Yeah, we usually allow an hour. For a prolonged exposure you often needed more, you would need up to 90 minutes,

but typically that would be like an hour and 15 minutes. For the first meeting you're just trying to get a general sense of where the client is at so that you can start making a treatment plan.

Q. Do you recall your initial impressions of Lionel Desmond when you first met him in individual counselling?

A. Yes, his depression symptoms were marked. Like he had what we call constricted affect. He didn't show much emotion on his face, his voice was soft, it was slow. Even movement's a little slower, not much animation in his voice. And his symptom severity we typically would measure that every session or every second session. His severity was at least in the moderate range with the instrument we used at the time.

Q. So, I think, is that the PCLS-6 ... or PCLS, is that the instrument that you're referring to?

A. Yes, like ... when we had the DSM-IV diagnostic manual, there were different criteria. So PCLS was based on a set of 17 symptoms rated from 1 to 4, and they had definite ranges for mild, moderate, severe.

And I cannot remember right now when we started using DSM-V and a slightly different measure, we call it the PCL-5 for DSM-V, and that one measured 20 different PTSD symptoms, and it went

from zero to 80, so ... But I believe that most of the time we were using the PCLS.

Q. And that was in the ... from the DSM-IV then was it?

A. Yes.

Q. So the score that you came to, I guess using that instrument in the first session was a 60 and you say that that's within the moderate range?

A. Yes.

Q. So what would that tell you about Lionel Desmond's situation having a score of 60 on the PCLS?

A. That's a pretty fair bet that they would have symptoms in all the categories. I mean, that would be a given anyway because he'd been diagnosed by Dr. Joshi. But you know that the symptoms were relatively high probably across all the domains of PTSD, including the emotional ones, the affective symptoms, and they were prominent. He had lost interest in most activities. He'd lost interest in socializing. He felt very distant from his wife and he was really very depressed.

Q. You say in the document that you and Lionel Desmond discussed the major aspects of his life that had changed since the 2007 tour and briefly touched on incidents of his tour, his triggers and his coping mechanisms.

So there's evidence that he was exhibiting symptoms or struggling with this since 2007. In your experience, is it surprising that a member would only start getting help perhaps years after starting to exhibit symptoms? Was that unusual or ...

A. Yeah. No, not unusual at all. I mean, it was not uncommon for someone to actually believe they were fine, or else believe that well, it'll go away or they just would deny it and keep on going. And so often it would be the spouse who would insist the person go and talk to their medical officer.

Q. Okay. Did you ...

A. And then sometimes they would. Yeah, sometimes they would. Like if ... You know, I remember some people, you know, they'd be really irritable and then they'd realize that one of their kids was scared of them and that would be a wake-up call and they'd come in. And I cannot remember what it was that precipitated Lionel Desmond coming for help. That probably was in Dr. Joshi's assessment report.

Q. Do you recall discussing initially his marriage or his marital situation with him?

(10:40)

A. Yes, and all he said is that it was distant. He

didn't elaborate at all. And then I came to discover that they didn't live in the same province; that she was in Nova Scotia and he was there in Oromocto and that they did not see each other very often.

Q. Did you ... Throughout your treatment of Lionel Desmond, did you have occasion to meet with his wife?

A. No, I did not. I always ask my clients if they would do that, if they would bring in their spouse or if I could talk to them but she was not ... she was always in Nova Scotia and she was very busy because she was training to be a nurse, she was at university, and so I don't believe it was possible.

Q. If the circumstances were different, you would have met with his spouse or you would meet with a member's spouse in those circumstances?

A. Yes, I do that whenever I possibly can because they offer really valuable insight about symptoms and things in the home and you can see just by looking at the way the two people relate to each other, you get a lot of information.

And then the spouse also has a chance to ask me questions. They might say, Well, you know, what kind of treatment is it, what will it do, what can I expect? They might have all kinds of questions and so it's very valuable to do it.

I know in one situation it saved the client's life that I knew the wife. But there were other military members who did not even tell their spouse that they were having treatment. They didn't even tell their spouse that they had PTSD or that they were coming for mental health treatment.

But in Lionel's case, it was just not possible he said for his wife to come in.

Q. In the document there's a section that says ... the plan, I guess, that you were looking at going forward and you say:

> To begin with behavioural activation and then to blend PE and CPT interventions. The client does not have a means of listening to recordings of sessions yet reading, writing is difficult for him and therefore the trauma-focussed part of therapy will present a challenge.

So, first of all, what did you mean or can you explain to us what "behavioural activation" is?

A. Yes. When somebody is very depressed they typically don't have much of a schedule and so what you try to do is get them activated doing something other than just going to work and

coming home, watching TV or sleeping or something. You encourage them to keep, you know, have some kind of regular schedule of activities on the weekend.

Some people do too little. They'll just lie around in bed all day or watch TV or play video games, and other people do too much. They'll be renovating the house and getting themselves exhausted. So we try to get people to have a look at their schedule and see if there's something about it that they would like to change and then get them to alternate activity and rest so that they have enough energy.

Because when someone is very depressed and having, you know, psychomotor slowing they really do not have much energy and they're usually not ready to start challenging their beliefs, you have to activate them and encourage them to eat properly and get regular sleep.

Q. Do you recall what observations, if any, you made about Lionel Desmond's activity level and diet and sleep, those types of things?

A. Yeah, I can't recall diet although it's pretty typical of military members living on their own not to put a lot of effort into meals. But I remember him, he said he had poor sleep and he really didn't have any interest in things. He said

even when he tried to do things he wouldn't enjoy them. And so when somebody is at that level of depression it's really hard for them to keep trying when they don't get any reward from it, if they don't enjoy something.

Q. Would you work on the behavioural activation with him or is that something that ... I think you had mentioned occupational therapists sometimes do that with the clients.

A. Yes, more recently there were occupational therapists in the private sector that we would get to help them, and they would actually do home visits and, you know, to see like is a person able to keep their place neat; do they have their fridge well stocked; do they know how to do a routine and it's really very helpful. But no, we did it by, you know, interviewing and having them fill out daily schedules and monitoring their level of mood over the day and in response to activities.

Q. Okay. And then you talk here about blending PE, which is prolonged exposure, and CPT, cognitive processing therapy, interventions. So why were you thinking about those two in particular and would be common to blend the different forms of interventions?

A. Well, normally, you would pick a dominant intervention and that would ... in that case it was prolonged exposure. But

I find some people have trouble challenging problematic beliefs just on their own. Like often it just happens spontaneously. They listen to the tape and spontaneously they start thinking differently and ... but they don't always. And so in that case I like to feel free to at least do some of the material from cognitive processing therapy but ... and so you just do what's needed.

Q. Okay.

A. And often the prolonged exposure is enough.

Q. Okay. And you had said earlier in explaining the therapies that cognitive processing therapy requires a lot of writing on the patient's part and that was a struggle for Lionel Desmond, was it?

A. Well, I can't remember what made us think that, it might have been from in the OSEP group. And with somebody very depressed, even if they're perfectly capable of reading and writing, which he was, it's a big effort. When someone is depressed it's a big effort to do anything and so you start small and work your way up.

Q. So for prolonged exposure, the telling of the story would be recorded. Would you typically give a recording device to the patient if they didn't have one or how would you

facilitate that?

A. Yeah. I mean more recently would tend to do it on their Smart phones. But back then our clinic didn't have a lot of recorders in the beginning but we did after 2011. Our clinic ordered several of them and we could lend them to clients. And so then he had one available without having to go out and buy one.

Q. Okay. So prolonged exposure was the primary choice for treatment with some elements of the CPT?

A. Yes, and I can't remember exactly, you know, even whether I needed to do that but it was nice to have that as a backup if somebody was having difficulty changing a belief.

And sometimes with prolonged exposure, it might be something they don't have beliefs about, like certainly not self-blame, sometimes it's just the horror and they've been avoiding it.

Because one of Lionel Desmond's incidents, probably the worst one for him, really involved a lot of horror. He knew he wasn't to blame. He had come across the body of a dead enemy soldier and it was a very horrific sight, and that was one of the things that haunted him.

Q. And do you recall if, at the very first session, if

you started doing the imaginal exposure or was that something that you were going to work up to in subsequent sessions?

A. Yeah, it took a while before he was ready to do that.

Q. Okay.

A. And it was really ... you know, once he was being more physically active, like once he started resuming doing physical training and his mood had lifted a little bit, and then he was willing and ready to do the prolonged exposure.

(10:50)

Q. Okay. Going forward, did you have a plan, I guess, about how often you would see Lionel Desmond?

A. Yes, usually we would see people once a week. Sometimes they'd have to miss a session like if they, you know, were ill or if they had a military thing. Lionel Desmond for a long time was with the military band and so sometimes they had to go off and play for an event.

Soldiers sometimes had appointments with general medical specialists, like if they needed shoulder surgery, and sometimes they had administrative things, like meeting with their career manager. And so people sometimes had to cancel sessions but our goal was usually to see them once a week during the trauma focussed part of therapy.

Q. Okay. And if I understood you earlier these, the various forms of treatment have sort of a structure in terms of how many sessions you need to do. And what was the prolonged exposure? Typically, how many sessions would that involve?

A. About 12 to 15.

Q. Okay.

A. And a lot would depend on how many events. We would address the most troubling one first, but sometimes they would have other ones that affected them in different ways and so we would go through whatever was needed until their symptoms remitted or improved.

Q. So if you engaged in prolonged exposure therapy with someone, meeting them say weekly, and at the end they continued to need help, would you ... what would happen? Would you start over or would you just continue with some of the particular aspects of prolonged exposure?

A. Yeah, you might do that at first, but if you really were not getting anywhere that would be the time when you would discuss it at the team meeting. Like we'd consult with each other. And so you might say I've got this client and he's had 15 sessions of PE and he's not any better and then we'd talk about other alternatives.

There's some things I routinely did. Like if somebody went through a session of trauma-focussed therapy and their symptoms were improved but they had something like recurrent nightmares, we have a separate treatment just for that. There's medical things that reduce nightmares and that would be Dr. Joshi's call. But there's things like imagery rescripting therapy that is helpful for people to reduce the intensity and frequency of recurrent dreams.

I had a private client last year who did really well with cognitive processing therapy but in response to certain triggers she had these really intense physical reactions so I did a few sessions of the EMDR with her and that took care of it. So, you know, there's some flexibility there.

Q. Okay. And you mentioned, of course, that there would also be treatment going on with Dr. Joshi in this case or a psychiatrist that would involve a drug regiment. Do you ... I appreciate that's the psychiatrist's area, but would you typically be aware of what the person was taking? Would you discuss that with the psychiatrist, say, Look this person is having really bad nightmares, I know one of these drugs is good for that? You know, ask them to look at it. Would that happen?

A. Yes, if I became aware of bad nightmares and I didn't see any discussion of that in the psychiatry notes then ... well, it would show up in my notes or I could actually, you know, tell Dr. Joshi, but he would usually be aware of those things. They have a couple of different medications they can use to help with nightmares and so ...

Q. All right, so that was the first session. Is there anything else you remember about your initial impressions of Lionel Desmond?

A. Yeah, I remember ... Like he had a really interesting metaphor to describe how he had changed from before his tour and after and I remember him saying, I used to be like Tigger and now I am Eeyore. And, of course, Eeyore is kind of the ... like the poster child for depression and so I found that a very evocative image.

Q. Right. So clearly he was exhibiting signs of significant depression then?

A. Yes.

Q. Okay. The next Psychology Progress Note that you completed was from February 9th, 2012, so about ... well, I guess two months later ...

A. Okay.

Q. ... that's the next that we have, I believe. You were seeing him though more often than that in the interim?

A. Yes, there's always a break where the clinic closes down for up to a couple of weeks over Christmas, but we always resume in early January.

Q. And I think you had said that at the time not all of your notes were being put into the system. Is that ... do I understand that correctly?

A. Yes, we started using the Canadian Health Information System ... Canadian Forces Health Information System. Our base started using it in 2009 and they rolled it out one base at a time across the country. And it wasn't at full functioning in the beginning and so we were not able to ... mental health clinicians didn't have the ability to enter our notes directly into the system. That came later. And it was really nice because you would enter the note and it would go right into the system and it would be available.

But, at the time, we would type in our note but the problem was it didn't go directly into the system. So there was ... I mean, there was a big staff, there was about 20 of us, and each person seeing several people a day. And so the only way to get it in the system was to have one of the admin clerks to scan it

in to the system and that was very time consuming and it actually became unworkable for the clerks to do that. They would have been doing all their time scanning in notes from all of us.

And so our military psychiatrist at the time, he made the decision that the psychiatrist's notes would always be scanned in but that we would only scan ours in every ten sessions or every couple of months, we just didn't do every one. But always our summary, we also did kind of a summary of things every three months, and so those would be scanned in and all assessment reports would be scanned in.

EXHIBIT P-000233 - PSYCHOLOGY PROGRESS REPORT - FEBRUARY 9, 2012

Q. So the next document again that we have marked and that we obtained is from February, that's Exhibit 233, but your recollection is you would have seen him, would it have been on a weekly basis between those two dates?

A. Yes. Yes, I mean, I don't have access to the system anymore but if there were any cancellations for any reason they would show up in the scheduler. But yes, I would have been seeing him probably every week.

Q. Do you have a recollection of how he did with the prolonged exposure and the activity of listening to his story at

home?

A. Yes. By then he was ready to do it and he did listen to it. Now I can't recall whether he listened to it every night but he did listen to it often in between and his distress levels about the event lessened over time.

Q. Was there a particular event that he described for the imaginal exposure or a series of events?

A. Yeah, I think there were at least two, and the one I remember the most was the one where he came across the body of an enemy soldier and it was really horrific. You know, the torso was open and intestines were coming out and there were flies and terrible smells. Like it was really a horrific thing.

Q. And so just so we have a sense, how long would the story be like that he would describe and then re-listen to?

(11:00)

A. It would depend. Like from every few minutes I would ask him what his levels of distress were, he would have rated them from 1 to 10. And I would get him to pick a beginning to the story and the end. And so the beginning might be when he was walking along. And I think it was on the other side of a fence. So the story would begin when he got to the fence and looked and saw this person and he would describe everything he

saw and what he was feeling, what he was thinking, and so ... you know, if he spent ten minutes on that, then at the end I'd ask him to tell his story again. And part of that was for the person to get habituated.

But I found it interesting how they would remember different things. If they told the story twice or even three times during the session each time they would remember something different.

Q. Okay. Was there an expectation how often they would listen to it at home in the week between sessions?

A. Yeah, we'd ask them to listen to it every night except for the day of therapy. So it'd be six times in between and that would be the most helpful because the worst thing would be if somebody avoided doing it and only listened to it once because it's that avoidance that makes anxiety worse. The more you avoid something you dread the worse the anxiety gets, but if you listen to it many times, then the anxiety about it doing it, and the desire to avoid thinking or feeling, dissipates.

Q. And would you typically ask the member if they had listened to it, say, six of the seven days or ...

A. Yes, I would ask them, you know, How did it go, how many times did you listen to it, what were your distress levels?

Like we often ... usually we'd ask them to record like, What was your worst level of distress and what was your level of distress at the end? And so they would be able to tell you how it went over the week.

Q. Right. So on this particular document, the one I'm looking at from February 9th, one of the ... there are a number of boxes at the top that have different areas, I guess, for examination such as mood, affect, sleep quality and so forth. On this form there's a box for suicide risk. How would you assess suicide risk? In this case it was marked as "none". And was that done in every session?

A. Not necessarily every session but when we did we would ask it often if somebody was in a lot of distress. And especially if they had a history of strong suicidal ideation. And we'd just ask directly. We'd say, Over the last day have you had thoughts of harming yourself? And if they say, No, and they, you know, seem convincing about it, then we don't probe further. But if they say, Well, yeah, a little bit over the last week I've had thoughts about it but I wouldn't do anything ... but we'd still inquire a little more.

We'd ask if they had a particular plan in mind or how often they thought about it, did they have the means to do it? We

would query further if there was any reason to believe they were having a lot of suicidal thoughts.

Q. In your experience and in your practice do you know has there ever been instruments, checklists, that type of thing, developed to assess suicide risk?

A. Yes, near the end of when I worked there. I think we even had one online, but there are typical risk factors you would look at and there's typical questions you would always ask and then over time we would often give something called the PHQ-9. That would be a depression measure.

And later on, I don't we used it routinely when I was seeing Lionel Desmond. But that one has a specific question about suicide, On how many days were you having thoughts of harming yourself or killing yourself? So if someone said "yes" to that we'd follow up on it.

Q. That instrument you mentioned, the PHQ-9, that's ... what does PHQ stand for?

A. Oh, Patient Health Questionnaire, and the dash nine just means there's nine questions.

Q. I see. All right, and that's an instrument that's sometimes used in assessing ... or can be used in part to assess suicide risk?

A. Yeah, certainly ... like, our clinic, we had several people take part in a Cognitive Processing Therapy study of how therapists used it and then ... for that every time we did the measure and then during the last year that I worked at the clinic, we had a method where people filled out certain instruments every time and it was entered ... they'd do it on a ... kind of an iPad, a Tablet, and the information would be available to us before the session started. But we did not have that system in place back when I was seeing Lionel Desmond.

Q. Right, so you marked his suicide risk at that time as "none". You felt that he didn't have a ...

A. Yes.

Q. A suicide risk.

A. Yeah, he would have said to me ... he would have denied suicidal ideation.

Q. I didn't ask you this earlier, but in your experience, the risk of suicide amongst individuals suffering from PTSD, can you make any comment about that as compared to the general population?

A. Well, I mean in a ... I mean anybody who has depression, suicidal ideation is very common and, in fact, somebody who suffers from depression, I believe that the risk of

a completed suicide is high as 15 percent. I'm not sure. I'd have to check that. And with PTSD, if there's a lot of self-blame or if there's a lot of beliefs concerning hopelessness about the future that would raise the risk, too.

So things like substance abuse, high levels of anxiety, expressed hopelessness, and big losses, those are some of the red flags that you would look for.

Q. Okay. In this particular document, the particular focus on that session, you called it psychomotor slowing. He was ... I think I have a sense from those words what that might mean, but can you explain that to us?

A. Yes. A person would be visibly slowed down. Their movements would be slower. Their speech would be slower. It would be more monotone. And they would have a sense of being slowed down. Like in the extreme case I've known of people with severe depression who would just lie in bed for a week and they would just get up, maybe, to have a glass of water or use the bathroom, and that would be it. They wouldn't eat. They wouldn't get dressed. They wouldn't shower. Usually some friend would find them and haul them off to a doctor. So that would be an extreme version.

But more commonly, we'd just see somebody who was just

visibly more slowed down, and that can be from depression on its own but, you know, some of the medications ... like, if somebody's being agitated or having trouble sleeping, then some of the medications they get could slow them down as well.

Q. And did you have a sense in his case if his complaint about psychomotor slowing was a function of depression or of side effects of his meds?

A. Well, it could be either one. It seems to me ... was at the session where he said that he had failed to fill a prescription?

Q. It is. Yeah, he was talking about risperidone, I think.

A. Oh, Risperdal, yeah. Risperdal. That's ... Dr. Joshi would commonly prescribe a very low dose of anti-psychotic, and I mean in the low doses, when you give it to somebody who's not psychotic - and Lionel Desmond was not - it would help somebody sleep and feel less agitated. And so it ... those are major tranquillizers. So they do slow someone down, and so if somebody has that ... I mean it's not my call. I don't know how to tell for sure whether medication is having an effect. So I would urge the person to talk about it with their psychiatrist or medical officer.

(11:10)

Q. All right. And on this particular occasion Cpl. Desmond, you said: "Will not be moved to range control until September. He feels discouraged and sees his current work place as, 'Like being in a nursing home'." And you go on to say: "He was very distressed that he has forgotten most of his weapons drills. Was at range yesterday." Do you recall what he said about his workplace situation and his duties?

A. Yes, he really did not like being in the band. Like, he had signed up to be in the infantry. That's what he did when he was on tour and for his career. So he didn't really see playing in a band as really, you know, his primary purpose in the military and they weren't always playing at events.

So he said sometimes he'd be sitting there all day just practising, and it sounded like he would often be alone. So you know, people who were musicians, they usually enjoy it if they're playing with other people but I think he found it boring and un-motivating.

But the other thing. He really had his heart set being transferred away from the band and doing range control because that would be more similar to what he was doing. That was a step back to being back to full duties.

Q. All right. Is that something that he brought up with you? Or I guess how would it come up in conversation, do you recall?

A. Well, he would have said. I mean he often talked about how much he did not like his placement working in the band but he often talked about how he wanted to start moving back to full duties.

Q. Okay. The next progress note, I guess, that we have is ... we've marked it as Exhibit 234. But it's from April 26th of 2012. So this would be another ...

A. Okay.

EXHIBIT P-000234 - PSYCHOLOGY PROGRESS NOTE - APRIL 26, 2012

Q. Another couple of months after the last that we spoke to. And it says: "This progress note covers sessions March to April 2012." In this particular progress note, at the top there's a box that says, "Treatment stage", and there's a variety of potential boxes to check there: stabilization, prep for processing, beginning processing, relapse prevention, crisis intervention, and others. And you have checked, "Prep for processing" and "Begin processing". I'm just wondering where you were in April in the Prolonged Exposure treatment, how far along you had gotten and ...

A. Yeah, from that, if it was preparation, then I would have been explaining to him what was involved and seeing, you know, whether he felt ready and able to do that.

By the way, that little form with all the boxes, that was something that our first military psychiatrist developed just so that we could more quickly rather than having to write a lot of text that we could tick appropriate boxes.

Q. Right. Okay. So the processes that you described earlier, the imaginal exposure and the *in vivo* exposure, do you have a recollection based on that where you would be? I'll just tell you that the document says: "Areas covered in treatment: assertiveness, behavioural activation, some *in vivo*, and imaginal exposure." So ...

A. Okay, so I would have started. That means I would have started ... just started doing it. And assertiveness, I mean sometimes that comes up as ... in behavioural activation when they ... if you see some other kind of problem like low assertiveness that's interfering in their ability to get what they need or want, then you would do some work on that. Because a person is most effective if they're not too passive and not too aggressive, if they're in the middle, able to state their needs and wants but not lose their temper and not be unable to

state their needs. So I don't remember the particular areas there but that would have been one of the things we worked on. And by then it sounds like he was becoming more active and doing more things. I remember at one point he resumed going to the gym and started getting back to his former level of fitness.

Q. The document does say that he had increased his level of PT. So that was ...

A. Okay.

Q. That was at your encouragement, was it, that he increase his physical activity?

A. Yes. Like all of his providers would have encouraged him to do that because it definitely affects mood if you're ... if you have a reasonable level of physical activity it can reduce anxiety and boost mood and then it's also a requirement of the military. If you're an infantry soldier you are expected to be at a certain level of fitness. So that's part of the recovery.

Q. Do you have a recollection of what the *in vivo* exposure was for Lionel Desmond, what you were having him do in the community?

A. Just getting out of the house more. Like for him going to the gym would be good because there would be other

people there. And probably, you know, going out to the grocery store more regularly. And I don't recall whether he had social opportunities. I know at one point when his daughter was living with him there was some nextdoor neighbours that had a child of similar age. So there was some social interaction there.

Q. Ultimately in this document you say: "Cpl. Desmond is beginning to respond to treatment albeit slowly." As compared to ... and I appreciate every case is unique but in comparison to other soldiers with PTSD who were engaging in Prolonged Exposure, do you have a sense of how successful the treatment was with him as compared to other patients?

A. Well, once he began doing the *in vivo* exposure I recall that he made progress quite quickly. His distress level went down and his symptom scores went down. And it would be nice to attribute that all to the treatment but he also had some things going on in the rest of his life that helped him, too. Like once he found out that he was going to be definitely sent back to range control and at times when he had his daughter staying with him, those things boosted his mood, too. So it's ... those things would contribute to his ability to participate in treatment and to benefit from it.

Q. I had marked a document. It's not yours. It's a

document that's entered by a nurse and we have it marked as Exhibit 235. And this particular document the nurse enters makes an entry: "Member self-presented at mental health intake this a.m. Wife sending him texts from St. FX indicating she wants a divorce." We've heard a lot of evidence about marital problems between the two. Do you recall throughout your treatment of him to what extent that impacted him and the struggles with ... between he and his wife?

EXHIBIT P-000235 – CAN001977 - ALLIED NOTE - SEPTEMBER 10, 2012

A. Yes, because I mean with them living in different provinces and not visiting very often ... I mean under those circumstances it's very difficult to repair any rifts in a marriage and when he said distant I think he really meant it. Because I know one time his daughter was with him over Christmas holidays and going back to spend time with his wife wasn't part of it. He said his daughter wanted to go shopping and so that's what they did over the break. And I remember being surprised by that. It sounded like, you know, he was either not feeling optimistic that things could be fixed or maybe avoiding the conflict. But he never talked a lot about it. He didn't talk about the nature of their disagreements and I mean he saw Dr. Joshi over a much longer period and he probably talked more to

Dr. Joshi about those things than he did to me.

(11:20)

Q. Knowing that there were potentially marital issues and that they were distant, is that something that you would allow the patient to sort of bring up if they felt comfortable or wanted to or is it something that you would typically probe a little bit about to see what's going on?

A. I would always ask more but if I didn't have any elaboration in the notes that meant he didn't talk much about it. Like I assume that he talked a lot about it with the nurse at intake, and of course it is a problem if somebody isn't aware that their wife wants a divorce and suddenly they get a text. And so he had gone to intake to ask for help for that, maybe seeking some time off to get legal advice. Or sometimes people would take time off to go spend time and find out what was going on. I'm not sure what exactly he did.

But it was a recurring theme, them being distant, and then when they were together he said they'd argue. But he didn't talk about any particular themes.

Q. Okay. The next psychology progress note we have, which we've marked as Exhibit 236, is from October 11th, 2012, and I just have a couple of questions about this document. You

say in the "Focus" section of this document "imaginal exposure". So I take it that he would still in October of 2012 be working on his imaginal exposure, listening to his recordings?

EXHIBIT P-000236 - PSYCHOLOGY PROGRESS NOTE - OCTOBER 11, 2012

A. Yes, and I don't know whether he would have been doing a second event by then and given the time gap ... I know in the summer the band would often be playing at events. So it's quite possible he had to miss some sessions when he was out of town. I know that the band typically would play at the Halifax Tattoo.

Q. Okay.

A. And during spring and summer there would be other military events like change-of-command parades and things like that. Because it does sound like a long time. I can't imagine that I saw him every week between April and October.

Q. And if I understand you, if a person goes through a session or a number of sessions of Prolonged Exposure about a particular event they can circle back and then record their memories of a different event and go through the process again regarding that particular event?

A. Yes, yes, and in his tour he would have experienced, you know, many severe events. Like for some people there was something happening every day, things like explosions and close-

calls with grenades and coming across dead bodies and putting bodies ... body parts into bags. There would be a lot in six months, and if there's one event that was particularly troubling you might have a couple of weeks where they would talk about the story in general, but if their stress level was high, then you'd spend some sessions zeroing in on the worst part of it.

Q. In this ...

A. And so in the case of that body that he came across I know one of the things that distressed him the most was the sight of the men's intestines all spilled out and the flies. And so I'm pretty certain we focussed on that particular part of the story for a while, too.

Q. In this particular document from October 11th you make reference to a scale or a rating called SUDs, S-U-D-S?

A. Yes.

Q. What's a SUDs rating?

A. Okay. That's a psychology acronym and it stands for subjective units of distress, and so early in Prolonged Exposure therapy we get people to be aware of their general level of distress of any moment in time. And so we ... ten out of ten would be the most distress possible. One out of ten would be if you were feeling very relaxed and comfortable.

And so we get them to think of situations where they might be at a one or at a ten and we get them to think of a situation where they'd be somewhere in the middle like a five so that they're comfortable. It's ... you know, it's a very subjective thing. Each person uses the scale a bit differently but the important thing is how that changes over time.

And so during Prolonged Exposure every few minutes I would say, Oh, what are you SUDs now? And so they would know what I meant and they'd give me a number between one and ten.

Q. Okay. All right. Because you say in this document: "His SUDs when describing the second incident reached eight out of ten, but he was able to return to baseline levels at the end of the session."

A. Yes.

Q. All right.

A. And what that meant is even if a person is high rate of stress when telling the event, which is very common, by the end of the session when they've finished and maybe I examined some of their beliefs about the event, then you check their distress level near the end. And if it was still reasonably high, like a six or seven, you'd get them to practise one of their coping skills like deep breathing or some kind of

grounding exercise so that by the time they left the session they were saying no more than a three or a four out of ten.

Q. That's where you would want them to be when they walked out the door at a lower level, I take it?

A. Oh, yes. Because it's not like ... like, we don't think they're too fragile to cope with eight out of ten because it's standard for people during a session, and even at home listening, their SUDs gets very high. But we want them to at least be feeling calm at the end of the session. So it helps them know that you can remember terrible things but it doesn't mean you're going to feel like that forever.

Like if we had somebody whose distress level didn't go down at all over a day then we would back off. Normally you'd be aware of that and you wouldn't even start PE if you had reason to believe that would happen.

Q. Right. In this particular entry you did say the focus - and this again was October 11th - was his marriage, and you said: "Cpl. Desmond refused to sign the divorce papers delivered to him. His wife is willing to consider reconciliation." I don't know if you recall now if he discussed actually receiving documents from his wife regarding a separation, anything of that nature now?

A. Yes, because I ... if it was in the notes it meant he told me about it spontaneously and that he refused to sign them and that his wife was willing to consider the reconciliation. But I don't know what they did about it because they were not in the same province. So we were not able to help them with marriage therapy and with her at university and him at the base it would be very difficult unless they were willing to each drive halfway in between, meet somewhere like Amherst and see a counsellor there. But I don't believe they ever did that.

Q. Okay, and I'm just going to ask you about just some entries in two other progress reports, psychology progress reports, from November of 2012. From November 15th. This one is marked as Exhibit 237. Again, it appears in this one that Lionel Desmond is engaging in imaginal exposure and listening to his recordings. In the plan in this document it says:

> He will continue to listen to the recordings of the last two most difficult PE sessions. I will contact the MO regarding recommending that this client have a chance to be exposed to the range and to have a chance to take courses. He appears very close to being able to be removed from TCat.

So at that stage, based on the plan, I guess, at that stage, where did you see ... what did you see happening with Lionel Desmond?

EXHIBIT P-000237 - PSYCHOLOGY PROGRESS NOTE - NOVEMBER 15, 2012

A. That he was less distressed with the memories and so ready to begin exposure to situations that were military-related. Because, really, playing in the band, he would have no exposure to anything related to infantry work, and so by going to the range he would be in the training area. He would be able to see people in training and learning how to use weapons. He would have been more exposed to the typical things that he would need to get used to, to going back to full duties.

(11:30)

Typically what happens is that somebody has to ... their symptoms have to remit but they have to remit in a stable manner like to be at low levels of symptoms for a couple of months before a medical officer would take them off their temporary medical category. And so that would be it. If they were not ... no longer avoiding general everyday situations, we'd want them to start exposing themselves to more real-life military situations.

And I've actually gotten people ... if they reacted

strongly to seeing military vehicles, I would get them to look at pictures or videos, because people could do that on their computer or their phone. But, in his case, it sounded like he really needed to see whether he could tolerate exposure to things like the range.

Q. Okay. And so his hope was to be removed from the temporary category, or TCat, and be able to return to the range?

A. Yes. I think he saw that as step one into getting back to full duties and ...

Q. Sorry. Go ahead.

A. Yeah. Because one of the big difficulties with people with post-traumatic stress, they ... you know, they're removed from their typical milieu and in Lionel Desmond's case, he did not have a sense of purpose in his alternative work at the band. And so that's one of the toughest things. If someone is trained to be a soldier and they thought that would be the rest of their working life, then they feel kind of lost and adrift without that sense of purpose or meaning. And so, for him, planning to go back, even starting to think about it, gave him a sense of hope and purpose.

Q. And you said, typically, to be removed from the temporary category, the person would have to have a remission of

their symptoms for an extended period of time?

A. Yes. It would vary from one MO to another, but I think typically it would be a good three months or so.

Q. And just from the entries ...

A. And it's partly ...

Q. Yeah. Go ahead. Sorry.

A. Oh! Because sometimes something unexpected would happen. I remember a different client who did really well in Prolonged Exposure and we covered the typical kind of triggers and he coped well with them. And then a couple of months after he stopped treatment, he and his wife had a baby. And when he held the baby in his arms, he had this really strong memory come back to him of wounded and dying children in Afghanistan and that got him all upset. But he was able to recognize what was going on and he adapted to it and he didn't need to come back. But we really watch for anything that we couldn't anticipate during those few months where they're maintaining stability.

Q. Well, let me ask you that and perhaps in a general sense. When a patient with post-traumatic stress disorder engages in treatment and does have a remission of their symptoms for a period of time, I take it there can be other external stressors that can cause them to relapse or regress fairly

quickly. Is that accurate?

A. Yes. I mean not necessarily with PTSD symptoms, but overall like depression symptoms and anxiety symptoms can come back quite quickly. And so something like marital discord or a conflict at work or even financial difficulties, all of those things, it's really hard to keep your mood high if you have too many other things affecting your life.

Q. And a person in those circumstances might be more vulnerable, would they, to those kinds of external stressors?

A. Yes, I mean when they're first getting back on their feet. And a lot of times it would depend on their history with those stressors, too. So, for example, if the marriage had been difficult for a long time, then if something suddenly happened, like divorce papers or a big argument, then that could cause someone's symptoms to go up. They might have strong symptoms of depression or anxiety.

Even things like physical pain. I've had clients who progressed very slowly in therapy and then something happened where their pain was less and maybe they had surgery or a different medication and when that stress of chronic pain was eased, then they were more able to feel happy and recover from depression or PTSD.

Q. Okay. So given that on November 15th, you were, I guess, contemplating speaking to Lionel Desmond's medical officer about him being removed from the Tcat. Had he had a period of, I guess, a remission of his symptoms or an improvement in his symptoms?

A. He had an improvement and I think by a few months later, he was still doing well.

Q. Okay.

A. And so the MO would have access to my notes and would be able to see that his treatment was going well and that his symptoms were remitting.

Q. Okay.

A. And they would take that as ... they are the ones that make the final decision, but they would do it by looking at what was happening with other aspects of their treatment. So they'd be looking at Dr. Joshi's notes and with mine.

Q. The medical officer would be the member of CAF, the medical member who's treating or was primary care physician ...

A. Yes.

Q. ... I guess. Is that ... do I understand that?

A. Yeah. Really, the equivalent of a primary care physician.

Q. Okay.

A. I think, in his case, he had different ones throughout time. Sometimes they had a physician and sometimes a nurse practitioner.

Q. Okay. And on that particular entry on November 15th, 2012, I guess you administered the test again. Now it's the PCL-S. So I guess we've changed from the PCL-5 to the PCL-S? Do I have that right or ...

A. Oh, actually, it goes the other way.

Q. Goes the other way.

A. PCL-S ... yeah. The "S" stands for "specific" because you're trying to get the person to answer the questionnaire in relation to the specific events. Because it's common for people to ... you know, if they had a dream about something completely different or if they were angry about something completely different, we try to get them to answer it with specific reference to PTSD symptoms.

Q. And on this occasion, he scored a 27 which you have in the minimal range.

A. Yes.

EXHIBIT P-000238 - PSYCHOLOGY PROGRESS REPORT - NOVEMBER 29, 2012

Q. Okay. And then following up on that, we have another progress note from November 29th, 2012, which we have marked as Exhibit 238. And on this occasion, you say ... in "Focus", you say, "Imaginal exposure complete". And you say ... you suggested to him that he focus on *in vivo* exposure to avoidant situations. This is the entry actually that you may have referred to earlier where he was not going to be visiting his wife over Christmas.

A. Oh, yes.

Q. And you conclude in the "Plan" by saying: "Treatment is winding down and Cpl. Desmond is ready to go back to CF courses." So ...

A. Yes. Okay. Yeah. So that's another step in somebody's improvement when they feel able to take the courses they would normally have. Like he was a corporal and so he would have been taking courses that would have prepared him for his eventual promotion to master corporal.

Q. Okay. So at that point, you feel ... or you felt that your treatment with him, the Prolonged Exposure Treatment was either winding down ... if not complete, it was at least winding down.

A. Yes.

Q. Do you have a recollection at the end of 2012 generally how he was doing?

(11:40)

A. Yes. I believe that was when he ... his daughter was living with him and his daughter really had a profound effect on him because he really loved her and her presence had great meaning to him. It gave him a sense of purpose. It made sure that he had a schedule because he had to make sure there were three meals and that she got to school okay and that he spent time with her evenings and weekends. So it gave a real structure and a meaning to his life. And he just ... he was calmer and happier.

Q. Okay. So is there sort of a, I guess, a benchmark or something you look for when you say, I think we've done enough Prolonged Exposure. I think that the treatment is over.

A. Yes. When I've discussed the events that trouble him the most and when they say there's nothing else that's giving them symptoms and those re-experiencing symptoms like spontaneous unpleasant memories that get them upset or nightmares. If they're not experiencing that and if they're able to go out in public and do their normal activities, if they feel interested in things again, and their symptom levels on the

PCL-S were below cut-off, then, yeah, it's ... we think they're ready. They're done that part of their treatment. It doesn't mean they don't have other issues but it means that part of the treatment is done.

Q. When you completed that, I guess, part of the treatment with Lionel Desmond, at that point did you consider yourself finished with him or you wouldn't be seeing him again?

A. I don't think I stopped seeing him until February. And so that note was from late November.

Q. Right.

A. I would have seen him after Christmas just to ... I mean to make sure that he was maintaining his gains and to check on whether he was going out in situations.

Q. Okay. And so that was in February of 2013 that you were pretty well concluded with him initially?

A. Yes. Because if he maintained his gains, if he still had a low symptom level from November until February, that would mean he was probably done that part of treatment.

Q. Is there ... when you say "maintain the gains", I understand what you mean, I guess, the improvement that ...

A. Mmm.

Q. ... that he experienced through treatment. In your

experience, was there any process by which you would check in with a patient you had treated with PTSD to see if they were maintaining their gains or would it be a situation where they would be referred back to you if they started having symptoms again?

A. Oh, you mean after treatment was finished?

Q. Yes.

A. Yes. I mean it's possible ... if somebody had a recurrence of PTSD several months after treatment, it's possible he would be referred back. A lot depended on how close the person was to being released. Because if somebody was within a year of release, typically they would look to have referral to an external provider or the OSI Clinic, somebody that would still be available after they left the Forces. So a lot depends on timing there.

EXHIBIT P-000223 - PSYCHOLOGY PROGRESS REPORT - SEPTEMBER 10, 2013

Q. Right. Okay. We do have another psychology progress note then from September 10th, 2013. This one, we have marked as Exhibit 223. And it says: "Client returned without going through Intake." And under "Focus", it says: "Relapse of mood and anxiety symptoms." And you have "R/0" which I assume means

"rule out non combat ..."

A. Yes.

Q. "... PTSD"?

A. Yes.

Q. Do you recall how he came back then to see you in September of 2013?

A. Yes. He would have just phoned for an appointment and the clerk would have given him an appointment but since I was no longer seeing him, I guess they just fitted him in on some empty slot that I had that day. And I hadn't seen him for a long time and I wasn't expecting him to come back. Because, normally, if somebody had recurrence they'd go to the Intake team and be interviewed by the nurse or the social worker on Intake. And then they could be re-referred through their medical officer or Dr. Joshi would have been aware and he would have had that option to suggest returning.

So the issue there was he was very anxious and ruminative and, by that, I mean dwelling on it, couldn't stop thinking about it, which is a common symptom of high anxiety or even depression symptoms. And so when somebody experiences a distressing event, it could be anything from a ... you know, a car accident to ... in this case, it was some racial comments

that other workers had made to him.

And so when somebody reacts like that, they can have very intense reactions. It doesn't mean that they're having a recurrence of PTSD, especially since what was happening to him didn't have anything to do with his events of tour. But it was certainly causing him a lot of distress and he needed help in dealing with it.

Q. Your entry, and I think you have a good memory of it, but it says:

> Cpl. Desmond cannot stop ruminating about a series of racial slurs and a particular incident of harassment in May of this year. He gets so angry that he fears that he would hurt someone. So far he has kept a distance from the person and his unit is taking appropriate steps to address this situation but he fears being sent back to the field where he would see the person he is most angry at. He has symptoms of re-experiencing numbness, avoidance, and hyperarousal related to this incident in addition to symptoms of depression.

So was it your understanding that the recurrence of many of those symptoms was as a result of the unpleasant event that he experienced in May?

A. Yes.

Q. Given his history and given his prior experience with PTSD and depression, was he more susceptible to experiencing those symptoms and reacting strongly to an event such as the one that happened in May than others might be?

A. Possibly, yes. And it would also depend on his experiences in the past because, you know, growing up in rural Nova Scotia, I believe he talked about some previous experiences. I know, at one point, he talked about every Friday night when he was in his late adolescence, the black kids and the white kids would get in fights. And so I don't recall a lot of detail about that but he certainly would have been exposed to racial comments throughout his life.

Q. This may have been something to which he was very sensitive but, in general, I take it from what you said that any event ... you described, for example, a car accident or marital strife or something such as this in a person like ... who's had the experiences like Lionel Desmond did, would make them more susceptible to relapse or to experiencing symptoms? Is that ...

do I understand you correctly?

A. Yes, because it's a significant psychosocial stressor to be subjected to racist comments. And I don't think ... like he never mentioned anything about that during his earlier time in the infantry. He was well regarded by his peers. And so I gather that that wasn't an issue for him during much of his time in the military. So it would have been probably a big shock. Maybe he thought that that was part of the past and he was free of it. So it would be, you know, extremely distressing and maybe unexpected to encounter it in a work situation.

Q. You said:

> The plan was to discuss with Dr. Joshi and submit a referral to Intake. Key decisions rest on whether his current issue is categorized as adjustment disorder regarding the harassment or a traumatic stress reaction to feelings of threat from past racial incidents.

Can you explain what that ... what those are, I guess what the adjustment disorder is and how you decided which it was?

(11:50)

A. I think I did not make that decision, but I thought

that, you know, Dr. Joshi or the MO would ... you know, once they had more information from Intake, would have a better feel for it. Adjustment disorder is when a person responds very strongly to a stressful event, the reaction is more temporary. Like when the event is over, they recover from it.

Now in his case, if he had been harassed in May and had comments later on, it sounds like it was kind of an ongoing thing and so that kept it going in his mind. But, yeah, adjustment disorder, they can get either with anxiety symptoms, depression symptoms, or even behavioural symptoms like acting out or drinking more, something like that versus ... it would be PTSD if it was triggering memories of something that I hadn't known about previously, like, you know, some events involving death or injury in his past that were connected to racism.

And I have not been aware of any such thing, although in that session, I think that's the one where he mentioned he once saved a friend from being stabbed. And I knew nothing about that before. And so if his reaction to the racist comments and harassment was really setting off memories of a traumatic event I didn't know about at the time, that would have been PTSD from non-combat causes and might have required further treatment.

But, in any case, if it was an adjustment disorder, it's

still something distressing. So it was helpful that the chain of command was taking steps to protect him, to keep him separate from those people. And I think, at one point, the people who had made the comments actually apologized to him.

Q. And do you recall if there was a plan to continue to engage in some treatment with him on an ongoing basis when he returned?

A. Not unless he would have been re-referred. That's why ... like being seen at Intake or by the psychosocial team, they could have helped him cope with the procedures related to the harassment and could have helped him cope with being exposed to people that make racist comments. But he would not have been referred back to Mental Health for therapy unless he was determined to have a diagnosable mental health condition.

Q. Right. Okay. How did he appear to you? Do you have a recollection? Was he ... his mood and presentation then?

A. Well, he certainly would have been distressed. And, like, rumination is a very painful experience because a person can't get something out of their mind and they just go over it and over it and over it, and it doesn't solve the problem or lead to a plan of action to cope with it. It just keeps the distress alive. So with ... I believe he saw Capt. Quinn in the

psychosocial team. And Capt. Quinn was very good at helping people get the skills they need to cope, like to stop themselves from ruminating or to calm themselves down. And so I don't know how much treatment he had there but I believe he was seen by Capt. Quinn.

EXHIBIT P-000227 - CAN051904 - EMAIL DATED SEPTEMBER 16, 2013

Q. Right. I had marked ... around the same time, there was an email to you from a Lt. Hounsell-Driver. That's from September 16th, 2013. We have it marked as Exhibit 227. And I just ... there's one entry in here that I wanted to ask you about. This gentleman spoke with ... or this officer, I should say, spoke with Lionel Desmond and he says in his email:

> I could see him getting very disturbed and, judging from his body language and tone, I believe that he became very angry. This anger ebbed and flowed through a few topics before he calmed down. The session lasted for about an hour. Another thing I believe I was picking up from most of his stories was a sense of paranoia.

When you ...

A. Hmm.

Q. When you dealt with Lionel Desmond ... or throughout the time you dealt with him, did you ever detect that, a sense of paranoia when he was discussing events or otherwise?

A. No. Because, certainly, if somebody is ruminating about something and they say they heard people making comments about them, it's ... I guess some people ... I mean you'd always want to know what exactly happened and to know ... to get a sense for whether it really happened or whether the person was just imagining it. Because if somebody was paranoid, then they might see two guys talking at quite a distance where you couldn't really hear what they said, and if the person imagined that they were talking and laughing or making comments, then that would be paranoia.

But the comments that he talked to me about, the people were close by and he heard exactly what they said. And so I did not see any evidence of paranoia when I saw him. And when he came to see me in September 10th, I saw no evidence of paranoia. Those things really did happen and the military chain of command was dealing with it.

Q. All right. We had ... I had asked you earlier about how one assesses suicidal ideation. Is there a way or would you ... when you're dealing with a member, is there a way to assess

homicidal ideation or assess whether they pose some risk to others?

A. Yes. You would ... if someone said, you know, I'm so angry, I'm scared I'm going to punch the guy out and put him in the hospital. I mean that's typically how somebody would say it, then, yeah, you would find out, you know, whether they really had a plan to do it or whether they had taken steps to avoid acting on their anger.

I would certainly ask them, you know, if they had plans. Like if somebody said, I'm so mad at this person, I just want to kill him, then you'd say ... you'd want to know who it was, what the plans were, did they have the means, did they really plan to do it, or was it just something ... kind of an image of something they wanted to do. Because there's plenty of people that get angry and they'll say things, Oh, I could just punch the guy or I wanted to choke him, but they don't follow through on it. They don't do it.

And so evaluating homicidal ideation, you would ask those kind of questions. And certainly when he went to Intake, those things would have been asked. And if somebody was in my office and had an urge to hurt somebody, especially kill them, and they didn't seem to have any self-control over the behaviour or means

to stop themselves from doing it, then in a case like that I would have a duty to warn the person who was the object of the homicidal thoughts and I did not do that, so I was satisfied that he didn't ... I mean he definitely did not want to act on it and he had taken steps. Like he didn't want to go back and work with those guys. His workplace had made sure he didn't have to work with them.

Q. You had mentioned a moment ago, Capt. Quinn, who was part of the psychosocial team.

A. Yes.

Q. Okay. So we ... I just marked an email that Capt. Quinn wrote on September 27th, 2013. That's Exhibit 241. And it's to a number of people: Janet Weber, who I believe is a nurse; Capt. Gilbride, and you're copied on it. And ... I guess it's noon.

EXHIBIT P-000241 - CAN051901 - EMAIL DATED SEPTEMBER 27, 2019 FROM CAPT. QUINN

A. Yes. That must sound very loud to you. I can hardly hear it with my headphones on.

Q. Well, it sounded ...

(12:00)

A. We have a friend ... we have a friend that, when he

visits, he gets us to turn the thing off because he can't sleep, but ... and I am really ... I apologize because if I'd thought about it, I would have had a way to turn it off this morning.

Q. It's really not a problem. It's ...

THE COURT: Dr. Rogers ...

A. Okay.

THE COURT: Dr. Rogers, it really isn't a problem for me either. I used to have a very old clock that had Westminster chimes on it and I used to enjoy it all the time and we never found reason to turn it off, so don't be concerned. Thank you.

A. Okay.

MR. MURRAY: The email that I was referring to, at the end of the first paragraph, Capt. Quinn says: "Member reports having bad dreams nightly, that he has poor sleep, daily fatigue, anhedonia, and problems with concentration." So it would appear that his relapse in symptoms were significant in September. Do you have a sense why he wasn't formally referred back to you for another course of treatment or do you think that may have helped, had that happened?

A. He would not necessarily have been referred back to me or even to mental health because, you know, Capt. Quinn ... if someone had referred them ... referred Lionel Desmond to Capt.

Quinn, he would've been more than qualified to help the member out because, yeah, it's depression symptoms. Anhedonia, that means a complete, like, an absence of pleasure, the inability to feel happiness or pleasure in things or interest in things. So ... and poor concentration likewise. So if he was ruminating and ... because, I mean from the last two things, two exhibits, you described, the last two or three, it sounds like if he'd gone back moving toward full duties, he would've encountered those two people again, and he did not feel able to do that. His anger was very strong and he couldn't think about it. And so certainly, he would've needed help. Like, he had access to Dr. Joshi, but I don't ... you know, I wasn't privy to the decision about where he would be referred or if he would be referred.

What I do know is, by that point, it sounds like it was clear that he would not be coming off his temporary medical category and he would not be returning to his infantry duties. So at that point, things take a different turn, and instead of trying to get them back to work, you're trying to get the client ready for the process of release. So that includes ... and then when we refer someone for therapy, we want them to see a therapist that could continue to see them after release. And so

even if he'd been diagnosed with PTSD again, which I don't believe he was, even if he had been, he probably would've been referred to someone long-term out in the community.

Q. If a member is in the temporary category but it would appear that they're not going to be able to return to their former duties and that they may be heading for leaving the CAF, in those circumstances, if they needed further treatment, would they be referred back to you in some cases or would it be more a situation where there would be a view to finding them treatment outside of the Canadian Armed Forces?

A. Definitely, if somebody ... once it's known that somebody is leaving the Forces, we want to make sure that they don't have a break in treatment. Like it would be quite difficult for someone to get ... return to me and then before they were finished, be released or be doing vocational rehab somewhere. And so whenever possible, especially in his case since his relapse of depression sounded quite serious, then it sounds like somebody who would need longer-term treatment. And certainly if somebody, instead of being removed from temporary medical category, was placed on a permanent category indicating release or medical release then, yeah, it wouldn't usually be suitable to send them back to us.

EXHIBIT P-000242 - CAN02111 - PROTECTED B DOCUMENT - MAY 13, 2015

Q. Okay. And I had just seen an entry, and I may have asked you about this when we met, but this was from a nurse, Alison Macdonald, from May 13th, 2015. It's Exhibit 242. And at that point, it would appear that, obviously, Lionel Desmond is going to be leaving the Canadian Armed Forces. The entry there says: "PTSD and MDE (which I take to be major depressive episode) both still active."

A. Yes.

Q. "Both still active. Never achieved remission. Referrals in place to OSI clinic." So it would appear, based on that entry, that he continued to struggle with some of his PTSD symptoms and depression but there was never another referral back to you. In retrospect, do you have any sense if that would've benefitted him if he had been referred back to mental health?

A. I guess I don't recall what symptoms he was receiving because ... experiencing because that was after the harassment.

Q. Right.

A. The harassment took place in May, so it was a few months after I had stopped seeing him. And so she said he never

achieved remission. That's surprising. Maybe it's because if she was new to him, she would've known he had symptoms and stopped seeing me, but then very soon after, he had a recurrence of all the depression and rumination.

Q. Right.

A. And so, yeah, it would've indicated he was vulnerable to stress and it sounds like, at that time, she was already thinking that he would not be returning to full duties.

Q. Right, okay. I have a couple of questions just about your experience with him. At any time when you were speaking with him, did he ever talk to you about having had head injuries?

A. No. And I mean I would've asked about it. If there was any indication in the assessment, I would've asked about that but, no, I hadn't ... as far as I recall and from what I saw in my notes, he never talked about head injuries.

Q. If a person did have a neurological deficit, I guess, as a result of a concussion or a head injury, would that potentially impact on how you would approach either prolonged exposure or CPT?

A. CPT might be more of a challenge because if somebody had cognitive difficulties, you would notice in things like

their ability to organize things, their memory, whether or not they were coherent, whether they complained of, say, recurrent headaches and had to see their MO about it. But none of those things happened. He was very capable of organizing things. Like when his daughter lived with him, there was no issues. He was always coherent. He could remember things. He described things clearly. Like I had no evidence that he had cognitive difficulties other than the typical mild ones that people get when they're depressed. When people are depressed, they often ruminate and their concentration is poor.

Q. In the period of time that you dealt with him, did he ever talk about his firearms license or personally having firearms?

A. I think he referred to going on a hunting trip once but I don't remember that ever being discussed with me. I mean if a personal firearm was an issue, that's something he would've discussed with probably Dr. Joshi or his MO, because in order to get a firearms permit, they typically ask for the okay from a medical doctor.

Q. Right. Later on, we know that to assist with his symptoms, Lionel Desmond used medical marijuana. I appreciate that this is perhaps more of a psychiatry question in

prescribing drugs, but do you have a sense from your experience, the effect of using medical marijuana on people who, for example, have depression or PTSD?

(12:10)

A. Well, at the time, it was a big issue for our clinic. We were quite distressed about it because some of the places that sold the medical marijuana, and they promoted it heavily and they had, of course, a vested interest, but some of them would tell our clients, you know, Don't take medication. It's bad for you, or, Don't bother with, you know, the psychology treatment. Take this stuff. They promoted it as something that would be a cure and it's absolutely not. And I know of some people, if they take the CBD component of marijuana, it helps them sleep better, or some people are helped greatly with physical pain, but it's absolutely not a cure, and we were angry that people were being misled. And at the time, people who prescribed it, prescribed sometimes enormous doses, and that's not helpful. Like, for example, one of my colleagues who does private practice, if someone uses medical marijuana and she's doing trauma focus therapy, she gets them not to use within several hours of the treatment because you want them to be fully alert and able to benefit from the treatment. You don't want

them to have any distraction or a different mood. You want them to be able to feel all their natural feelings and to think straight.

And I mean some people were being prescribed ten grams a day, and people who use it recreationally just say that's a crazy amount. And one of the later psychiatrists, our military psychiatrist, he said that people who did the large doses of it sometimes reacted badly. They would get paranoid and have strong symptoms. So it was not something we encouraged. Like, once it was legalized, there was nothing we could do to prevent it but they definitely ... if somebody was using medical marijuana, they weren't allowed to drive military vehicles because they needed to be fully alert.

Q. Right.

A. So it was quite contentious. And I guess the other issue with marijuana, there's a real difference from the stuff that was around in the '60s and the '70s that people smoked recreationally. The more ... with the current marijuana, things have changed. They've modified it probably ... I'm not even sure how we do it, but anyway, the current marijuana is much stronger and it has a much higher proportion of the THC to some of the other ingredients. The old-style marijuana from the '60s

and '70s had a high degree of the other ingredient, some of which would counteract tendencies to psychosis, because some people really do get paranoid if they smoke a lot of weed.

Q. Right. And a patient primarily taking more of the CBD, if you can express an opinion, do you know if that poses less risk?

A. Yes. Supposedly, it has only minor psychoactive effects. That's the one that people typically take for pain.

Q. Dr. Rogers, I appreciate that your treatment with Lionel Desmond ended primarily in February of 2013, other than the visit in September but did you have a sense ... maybe you can't answer this, but what he might've needed when he left Canadian Armed Forces? What ongoing treatment or care would've benefitted him?

A. Well, people, you know, they need to have a plan. Like they have the option of doing some vocational retraining, so if he'd had a sense of what he wanted to do that would've been helpful. Like a sense of how he would make a living and how he would fill his time in a meaningful way. And certainly, if it had been possible, he would've been offered marital counselling because that would be a big factor too. Like if the marriage was in trouble over a long period and they were really

estranged from each other, then it wouldn't necessarily get fixed if he was discharged and moved back there, because also, I understand the Guysborough area is very remote. It's far from places like Halifax where there'd be OSI clinics, and even far from treatment providers.

Q. And those geographic challenges, have you seen that with patients that you've treated in the CAF after they leave? I don't know if you would have contact with them or be aware of those challenges, but have you seen that?

A. Yeah. I mean I remember a documentary. It was years ago. I think it was a CBC thing. And they had such a pessimistic view of PTSD. I think they had interviews with guys who would leave the military and they'd buy some land in some really remote area and they'd never have much contact with people. Maybe they'd buy a little hobby farm. And so those people, their symptoms would tend to get worse because they didn't have regular contact with people or any situations like the guy in that documentary.

I remember he had trouble when he went into a town and sat in a restaurant. Even the noise of the cash register bothered him. So it's generally not a good idea to do what people with PTSD often want to do. They want to avoid anything distressing.

And so you want them to be able to function at a normal level, to be able to go into stores and visit friends. And if they're having any trouble with that, you hope they would live somewhere where help was available.

Q. For individuals ...

A. And where they would have a job, yeah.

Q. Yeah. For individuals who might be susceptible to relapse based on some external stressor, if they're in a remote area or an area further removed from services, does that pose a risk or a potential problem?

A. It certainly did then because, you know, the pandemic has had a huge benefit in one way. It enabled ... it really got people to make themselves available via video. And if somebody was in a very remote area, back then they might have to drive two hours to see a therapist, and that's really difficult in the winter. Sometimes it would not be possible. And a check-in by phone, it doesn't really do the job. And so it is, it's risky, because if somebody is not functioning well and they live far from help, that's an issue.

Q. The face-to-face contact is important then in helping people in those situations?

A. Yeah, because ... I mean I've ... they were

pessimistic at the beginning of the pandemic about whether a video would work well but the vast majority of clients still find it helpful. There's the odd one that just doesn't want anything else except face to face, but you can still see things, you can ... if there's worksheets for them to do, you can email them to them. It's easy to do most kinds of therapy. Not EMDR, but other forms of therapy, you can do remotely, but in those days, people were not equipped.

Q. Have you done some therapy by video during the pandemic?

A. Yes. I stopped seeing clients in the office. Probably my last time was March 16th, 2020. And so I've finished working with some clients and started working with new ones and, with one exception, it's worked well. The other guy, he switched to a therapist that was seeing people in the office. And it has worked very well. Not EMDR. The one exception I made. I had a client who needed EMDR, so I saw her for a few sessions in the office and I scheduled it on a Monday when nobody had been in that office for three days, and we both wore masks and we were at a distance because that building does not have good ventilation.

Q. All right, thank you, Dr. Rogers. Those are all the

questions I have.

A. Okay.

THE COURT: Thank you, Mr. Murray. Dr. Rogers, we've had you online this morning for almost two hours and I think we're going to take a break for lunch. It's about 20 after 12.

A. Okay.

Q. And we typically take an hour and come back around 1:30.

A. Okay.

Q. Would that be convenient for you?

A. Yeah, that would work well for me.

Q. All right. Appreciate that. So we may just try and establish the link with you sometime, maybe about 1:25 or thereabouts?

A. Okay. So I mean, in terms of technical stuff, do I just leave this screen live or do I have to log out and ...

Q. If you just leave it live, that would be fine.

A. Okay. That's what I'll do then. And you want me back at 1:30.

Q. Maybe about 1:25 to 1:30. That would be fine.

A. Okay. I'll be there.

Q. All right. Thank you very much, Dr. Rogers.

A. You're welcome.

Q. Thank you. All right. We'll adjourn to 1:30 then, thank you.

COURT RECESSED (12:22 HRS)

COURT RESUMED (13:31 HRS.)

THE COURT: Good afternoon.

Mr. Anderson, do you have any questions for Dr. Rogers?

MR. ANDERSON: I have no questions. Thank you.

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

MR. MACDONALD: I have a few, Your Honour, yes.

THE COURT: All right. Thank you.

MR. MACDONALD: I'll move to the podium.

THE COURT: I might ask you to use the podium if you could ...

MR. MACDONALD: Yes, I will. Yeah.

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

CROSS-EXAMINATION BY MR. MACDONALD

MR. MACDONALD: Good afternoon, Dr. Rogers.

A. Good afternoon.

Q. My name is Tom Macdonald and I am the lawyer for the

Borden family. So that would be Cpl. Desmond's late wife and daughter's family. So the grandparents and the parents.

A. Okay.

Q. In your meetings, your sessions with Mr. Desmond, did you notice a theme of anger from him generally?

A. Not generally. The first time he talked about ruminative anger was in relation to the racial comments but generally, no, he did not. He was resentful about having to work in the band, but it was resentment, not anger and with no expressed wish to do anything about it.

Q. Did he ever express in your sessions anger toward his wife?

A. No, it was ... like it was very strange. It was like an indifference and I've seen that in military members before where they feel estranged from their wife and, you know, that symptom of anhedonia means it's difficult to feel love and happiness. But that's more what it was, like irritation or just ... I don't know about indifference but it's just a distance. It was like an avoidance almost.

Q. Did you ever specifically ask him if he was angry with his wife?

A. No, I did not.

Q. Did you ever specifically ask him if he had ever any intention to hurt his wife?

A. No. I mean it was not ... he almost never saw her and so those kind of things didn't come up. Like he was distressed when ... in those times when she texted him about wanting a divorce but he didn't express anger. It was more anxiety, worry.

Q. You mentioned in your evidence this morning to Mr. Murray, and I'm paraphrasing, that you thought it helpful, in some of your patients at least, to bring in the spouse or significant other. I don't think you used that word. But spouse into treatment if I can put it that way. And you explored that issue with Cpl. Desmond but he indicated to you that because of school and distance in Nova Scotia and other, perhaps, commitments that his wife would not be able to do that, is that fair?

A. Yes, because, certainly, I offered it. It's something I always want to do, but it was my understanding that when there was visits it would be on a weekend or during Christmas break or something when the clinic was closed.

Q. Did you ever raise the possibility of reaching out to Shanna Desmond directly by telephone or other means to see

whether she would participate?

A. No, I did not ask her directly. Actually, I would not have even been allowed to. Like we always had to get consent from the client so ...

Q. And so did you ever ask him for his consent for you to approach her directly?

A. No, I did not. I just asked him to talk to her about it.

Q. And so it's fair to say that in terms of your impression that she would not be attending, you relied on Cpl. Desmond's relating those facts to you that she couldn't attend? You relied on what he told you.

A. Yes, yes, and there's no way I could have called his wife to confirm that. I did not have any reason to doubt but ...

Q. Well, when you say there was no way I hear you say you didn't have a reason to doubt. But if you had asked him, Can I call your wife, do I have your permission, I guess you could have done that. That's possible.

A. Yes, I could have.

Q. Okay.

A. Yeah. And sometimes in a situation where there's two

clinicians involved maybe a family member would talk to Dr. Joshi. He would often have a spouse attend part of the assessment but, you know, the spouse might not want to go out of their way to see two different people.

Q. It's possible, isn't it, Dr. Rogers, if Shanna Desmond had have been contacted that she may have participated and, therefore, that might have been of assistance in his treatment? Possible?

A. It's just conjecture because ...

Q. Well, it's possible though.

A. It's possible. Oh, yeah, certainly, it's possible and there's nothing to stop a family member from contacting something like ... someone like the medical officer or clinician. We would not be allowed to divulge anything to them or even acknowledge but if I became aware that a family member wanted to speak to me then I would get written consent from the client.

Q. And if you had spoken with Cpl. Desmond's wife, or she had attended the session, a session would those ... anything she had to say have been reflected in your notes, ultimately, your progress notes?

A. Oh, yes, yeah. Yeah, and you know, I don't know

whether it would have been helpful because I never had the opportunity to speak to her.

Q. Were you surprised when you heard what happened with Cpl. Desmond and his family?

A. Oh, I was deeply ... deeply shocked. It's a rare event anyway. I would not have predicted it and particularly that he killed his daughter because he loved that little girl.

Q. Of course hindsight is a great thing in retrospect but now looking back, did you see any warning signs when you look back now at then when ... through your sessions with him?

A. No, no warning signs of violence toward the family at all. Certainly, knowing what happened, I think it's regrettable that he ... that somehow ... I think he didn't get enrolled in New Brunswick Community College to take training. It's regrettable that he lived somewhere where resources were difficult to come by and so that's regrettable. But there was no warning signs.

Because typically, like an abusive husband that's prone to family violence, it would show up because he would ... you know, if somebody spoke in derogatory terms about their wife or if they tried to control her movements. But I mean clearly, he did not at all. He ... you know, she was off in Nova Scotia going

to university and working and so they didn't see each other very often. So he was not attempting to control her. He never spoke about her in a derogatory way. There was just nothing that raised red flags for me except knowing that they were unhappy and distant. I didn't feel optimistic about the future of the marriage.

(13:40)

Q. Possible though, and just circling back here, that if someone had been in contact with Ms. Desmond that that discussion may have raised red flags. That's possible.

A. Be purely conjecture.

Q. Possible, though, wouldn't it have been?

A. Because ... oh, yeah, yeah.

Q. Those are my questions.

THE COURT: Mr. Macdonald, I'm just going to stop you for a second.

MR. MACDONALD: Oh, I ...

THE COURT: Part of the premise of your question is that you're assuming that she would even want to talk to Dr. Rogers.

MR. MACDONALD: Yes, and of ...

THE COURT: That she would have any interest in calling or having any interest in the discussion. So when you say is it

possible you have to start with ... first off you have to assume that she did, and we have no evidence that she had that interest.

MR. MACDONALD: Well, we don't in that respect with Dr. Rogers, Your Honour, but we do have evidence that of course she was part of the Ste. Anne's treatment and she spoke with the Ste. Anne's ...

THE COURT: Well, we'll get to that but ...

MR. MACDONALD: We'll get to that but ...

THE COURT: ... we're talking about Dr. Rogers at the moment.

MR. MACDONALD: We are.

THE COURT: Okay.

MR. MACDONALD: We are.

THE COURT: Thank you.

MR. MACDONALD: But I'm just ...

A. Mm-hmm.

Q. ... making the point that, you know, a call could have ...

THE COURT: Well, there's another ...

MR. MACDONALD: It's possible ...

THE COURT: ... premise that's part of your question

here ...

MR. MACDONALD: If he consented.

THE COURT: ... and that's assuming that she had the interest, and if she had the interest then perhaps ...

MR. MACDONALD: Yes.

THE COURT: ... we would have expected she'd pick up the phone call and talk to Dr. Rogers.

MR. MACDONALD: Well, I guess my point, Your Honour ... I take your point. But my ...

THE COURT: Thank you.

MR. MACDONALD: My point would be, from all of the evidence we've heard in this Inquiry to this point, that Shanna Desmond was very interested in her husband's treatment and everything that went with it.

Those are my questions, Dr. Rogers. Thank you very much.

THE COURT: Thank you.

MR. MACDONALD: Thank you, Your Honour.

THE COURT: Ms. Miller. Ms. Miller, could you use the podium, please?

MS. MILLER: I will.

THE COURT: Thank you. Thank you.

CROSS-EXAMINATION BY MS. MILLER

(13:41)

MS. MILLER: Good afternoon, Dr. Rogers. My name is Tara Miller.

A. Good afternoon.

Q. I represent ... Just to orient you. I represent the late Brenda Desmond and share representation with Mr. Macdonald for Aaliyah Desmond. So Brenda was Lionel's mom, and Aaliyah, of course ...

A. Yes.

Q. ... was Lionel's daughter. Just a few ... I just want to clarify a few pieces of information from some of the documents that were put to you this morning, and I'll try to go through them slowly. But Exhibit 232, this is ... I know you don't have it in front of you and we'll have ...

THE COURT: I think actually ... I'm sorry. I think we have the ability to call those documents up. No?

MS. MILLER: Okay.

THE COURT: We lost ...

THE CLERK: It went down again.

THE COURT: It went down? I'm sorry. I ...

MS. MILLER: That's okay.

THE COURT: I thought we had it for a while.

MS. MILLER: I'll reference Dr. Rogers ...

THE COURT: Okay.

MS. MILLER: ... the specific documents so that you have a background for it. It's Exhibit 232, and that is, as I understand it, a December 1st, 2011 psychology progress note.

A. Okay.

Q. And I understand that was the first from your note. It says: "This was the first visit for individual therapy." And that's certainly what you had indicated this morning. My only question on this is, in that note you write: "He described four triggers that are particularly difficult for him." Do you remember what those triggers were?

A. I don't. I know that going out in social or in public situations was difficult for him but I don't recall the exact triggers. I certainly know the typical common ones.

Q. Okay. Appreciating that you aren't able to recall the ones that were expressed by Cpl. Desmond, can you share with us what some of the common triggers would be?

A. It would be sight, sounds, and smells. Like for many people the smell of diesel reminds them of military vehicles. The smell of, you know, anything that's rotting, like vegetables

going bad in the fridge, could easily remind them of times when they had seen decaying bodies in Afghanistan. Because it was so hot over there bodies decomposed very fast.

Q. What about sounds as a trigger? Like loud noise.

A. That's common. Loud noise. Loud, sudden noises, because he would have heard everything from artillery to grenades to incoming rocket attacks. He may have heard explosions. It's a very noisy environment.

Q. Okay. Do you remember if noise was a trigger for Cpl. Desmond?

A. I remember ... I don't remember him saying that specifically, but I think I saw something about ... oh, no. It was certainly not during the time I saw him, but often people with PTSD feel overwhelmed in loud, public places. Probably because they're hypervigilant and they feel like they have to be able to see everybody to know what everybody is doing and to be what they call situationally aware and because they're trained to be very aware of potential danger. And if there's too many sights and sounds coming at them it can be overwhelming.

Q. Thank you. When you worked with Lionel initially the plan for him was he wanted to get back onto the range, is that your recollection?

A. Yeah, I think he eventually wanted to go back to full duties but, you know, being ... working for the band, that was like an alternative duty that would allow him to have nothing stressful happening while he was under treatment. But eventually, people want to do things like take their military courses or at least be out on the range where they're exposed to typical military milieu.

Q. Right.

A. That's part of getting back to full duties.

Q. And he had been able to get back out onto the range with the intention of returning to that area of work, is that fair to say?

A. I believe so. Like he was due to return to the range in September, and that's probably where one of the events with the racial comments happened, but I wasn't seeing him at that time.

Q. Fair enough. And that's one of the things I wanted to ask you about. Because from ... I'm looking at Exhibit 238, and this is a psychology progress note of you dated November 29th, 2012. At this point under the item in the document that says, "Focus - work data", you write:

He wants to go on courses as soon as

possible but he enjoys working at Stores. The unit may keep him there permanently. He had to turn down another offer to go to the range control because the 12-hour shifts would not be possible now that his daughter lives with him.

So from that I take it ...

A. Oh, okay.

Q. I take it that he had been moved. He had progressed out of the band unit and it looks like but for the fact that his daughter was living with him and there were 12-hour shifts involved with being on the range that that likely would have come to fruition. Does that help? Do you remember that?

A. Yes, that makes sense. Yeah, because the military store is ... again, it wouldn't be a job where he was doing anything related to combat training but it would be where he would sort of manage and dole out equipment as needed.

Q. Okay.

A. And it would most ... I guess it would be a day job.

Q. Yeah. And at that point his daughter, Aaliyah, was living with him. Do you remember if his wife was living with him at that point?

A. No, probably the reason that Aaliyah was living with him is his wife must have been doing shift work or very intensive course work at the time. But I think it was probably shift work. And since Lionel was able to work days when his daughter was at school and to be home evenings and nights then it made sense for her to be with him.

Q. Right, so her was parenting her, and I think you said that was one of the things that, you know, from your perspective, gave him structure around his day.

A. Yes.

Q. He had to get up, prepare meals, and that was a very positive thing for him to be living and parenting with Aaliyah.

A. Yes, because it really ... it meant a lot to him.

Q. Okay.

A. It wasn't ... he didn't express it as a burden. It was something that gave him joy.

Q. Thank you.

A. Yeah.

EXHIBIT P000239 - CAN001996 - DOCUMENT - FEBRUARY 26, 2013

Q. I'm going to turn now to Exhibit 239, and I appreciate that this is not your document. I think it was addressed this morning though. Your evidence, Dr. Rogers, was that you had no

appreciation that Lionel had had any concussions or any mild traumatic brain injuries at all during the course of your work with him. Is that correct?

A. Yes. I mean I know that people in the military, they'll ... I mean they're bumped around a lot when they're riding in military vehicles, whether in training or in Afghanistan, but he never said anything about, you know, being knocked out or hit on the head.

(13:50)

Q. Okay. You described for us ... I'm not going to get the name right, but there was an online medical records system that you were able to access. What was the name of that again?

A. Oh, CFHIS. Canadian Forces Health Information System.

Q. Okay, and I think the question as it was put to you is that you would have looked at that prior to seeing Lionel at least to see the assessment that Dr. Joshi would have done and there may have been some other documents that you looked at in there.

A. Yes.

Q. But would you have had opportunity to look at those records, Dr. Rogers, for any physical issues like x-rays or, you know, sick patrol notes, things like that? Would that have been

something that you would have spent any time looking at?

A. Probably not in-depth but I tended to have a look at the file. I mean my first thing I would look at would be the assessment, and there's always a section on physical illnesses, injuries, history of head injuries and things like surgery. So I would have looked at that and I usually look at the MO referral note and sort of recent MO visits. So usually I'd be aware of medical issues.

Q. Right, the MO being the medical officer who would have initially referred ...

A. Medical officer.

Q. Referred Cpl. Desmond to the mental health unit. Okay, so this document ...

A. Yes.

Q. ... that ... I appreciate you can't see it but I'm going to try to describe it for you. It's certainly a CAF ... a Canadian Armed Forces document. It says it's dated 2013-02-26, but it looks like it's a bit of a running note. Because that's February 26th, 2013. And we see a history of presenting illness. Then we see a note 06-September-13: "Member wishes to release from the CF ..." and it goes on.

And then it goes 29-October-13: "Member continues to

deteriorate. Has increasing frequency of SI and HI. He does not ever see himself being able to deploy in the future." The ... I'll also give you some context. The end of these document, the two-page document, says it's signed by Ms. Janet L. Weber, NP. And ...

A. Okay.

Q. And Janet Weber is a nurse practitioner. Correct? Do you ... are you familiar with her?

A. That's right. So she would have ... yes, yeah, I knew her and she would have been his MO at the time. Because an MO, medical officer, really can refer to a physician, whether civilian or not, or a nurse practitioner or a physician assistant.

Q. Okay. So I'm not quite sure of the purpose of this note but she does note that as of October 29th, 2013 that there was increasing frequency of SI and HI. Again, your ... you were never ... he was never referred back to see you, although we know from the records ...

A. No.

Q. Yeah. He continued to be followed by Dr. Joshi.

A. Yes.

Q. Under "Past Medical History", which appears to have

been in connection with the October 29th, 2013 note it says "Surgical/Medical/Psychiatric", and of course we see: "Post-traumatic stress disorder, PTSD, diagnosed in 2011. Processing complete beginning 2007." Above that it says, "Trauma"," and then as I read this it says: "No#, LOC, concussions."

Again, I know you don't have that in front of you but from what I've read to you ...

A. Mm-hmm.

Q. ... what would that indicate to you that it means in terms of his past medical history as of October 2013?

A. With concussions, it sounds like no loss of consciousness due to concussions.

Q. Okay. Do you ...

A. But the MOs use a lot of abbreviations.

Q. Do you take from that that he had concussions?

A. No, because it said, "No LOC concussions." So no loss of consciousness from concussions.

Q. Okay, and again, I appreciate this is not your note and perhaps the best person to speak to ...

A. Mmm.

Q. ... would be the author and ...

A. Yeah, Janet Weber would know that.

Q. Yes, yeah, I just ...

A. Yeah.

Q. I noted that under "Trauma" and I wondered if you were able to provide any insight for us into whether that meant he had concussions or he didn't have concussions. Maybe no ...

A. I would interpret that to be no.

Q. Okay.

A. Yeah. No, and in fact, you know what? The number sign might ...

Q. Might that mean fractures?

A. I mean I don't know whether that's a shorthand for "history". Yeah, it could be fractures or ...

Q. Could be fractures, yes.

A. So no fractures or loss of consciousness or concussion.

Q. Okay. Thank you.

A. And typically, if there was an injury like that where a person lost consciousness there would be ... I can't remember the name of the form but it would be documented somewhere. The person would have had to see a physician and there would be a note on the medical chart. Even if they saw a physician at a local city hospital a copy of that note would get sent to the

Canadian Forces and it would be put on their chart.

Q. Would that have happened if he was injured in Afghanistan? You would expect a note would have been issued that would then make its way back to the Canadian chart?

A. Yeah. There was some form that got filled out if somebody had an injury on tour because they had medical units in ... wherever people were deployed there was a medical unit. And so if somebody had a problem that needed seeing to they would see ... they'd see a physician or a PA or a medic ...

Q. Right.

A. ... and there would be a note and a form filed to indicate the nature of the injury. And to my knowledge, there was nothing like that on his chart.

Q. Okay, and that, of course, presupposes that there was an actual injury for which a member would then seek medical treatment as opposed to just ...

A. Yeah.

Q. ... shaking it off and moving on.

A. Yes. So yeah, sometimes in the heat of battle they don't even think to do it.

Q. Thank you.

A. But we never ... he never said anything to Dr. Joshi

and it looks like he would have denied ever having that problem when Janet Weber asked him. And we didn't know ... notice any signs of cognitive impairment.

Q. Okay. Thank you. So from your evidence and the documents we reviewed this morning, the last time ... you did the treatment, PTSD treatment, with Cpl. Desmond with your last psychology progress note before one visit in September of 2013, but your last treatment note that we have is Exhibit 222. And that is dated February 19th, 2013 and my read of that, and your evidence is that Cpl. Desmond had responded well to the Prolonged Exposure therapy. And at that point you ... from your perspective, therapy was completed and his file with you was closed.

And you indicated, "Cpl. Desmond appears ready to be removed from Tcat (the temporary medical category) and his case will be discussed at this week's mental health team meeting at which Dr. Joshi will be present." Would you have been present at that weekly mental health team meeting?

A. Yes, we ... the team attended them every week. Dr. Joshi was not always able to attend. It depended on if it was a day when he was working and what his caseload was like.

Q. Yes. So ...

A. But certainly he would have had access to the notes. So he would have been aware.

Q. Okay. You at that point, from your perspective and I believe you said earlier this morning there would be other things that would be considered to remove somebody from a TCat, but from your perspective, you believe that there had been successful completion of the therapy such that you felt that Cpl. Desmond was ready to be removed from that category and transferred back into the regular, I guess, fit-for-duty category. Is that fair to say?

A. Yeah, yeah, or at least ready to be considered. Because I mean the MO may have other things. Like some of them wanted to wait a little longer.

Q. And so who ... what other people would have had a role in determining the removal from TCat or escalation to another category?

A. It would mainly be the medical officer, but she would have taken into account, you know, not just my treatment but Dr. Joshi's treatment, like the level of medication that he still required and his general functioning and because that was the year his daughter was with him they didn't get a chance to see how he'd do on 12-hour shifts in the range because that kind of

thing could be important, too. You see how somebody reacts with a very long work day.

Q. And his medical officer, was it always Janet Weber or could it be different people?

A. It'd change. Like, generally, if someone had a nurse practitioner that was fortunate because some of them have been there over long periods. And so he would have the same person. But I seem to recall that earlier on he had a military physician. I think he saw Dr. MacDonald.

(14:00)

Q. Okay.

A. And Dr. MacDonald, I know, was away from the unit for a few years because he took his residency in psychiatry.

Q. Okay. So I want to go to Exhibit 242. And, again, this is not your document, Dr. Rogers, so you may not be able to help us with this. But I wanted your insight on how I interpret this document. So on February the ... the last time that you see Cpl. Desmond, you're contemplating that he would be appropriate for removal from the TCat. When I look at this document, it says "History". Although it's dated 2015/05/13 ... so I take from that May 13th, 2015. But it's sort of a running note. It starts with "History of Present Illness". It is

signed by ... it's a three-page document. It's signed by Alison Macdonald, who is a nurse practitioner, as well. So would she have been the medical officer?

A. Yeah. For some reason, she would have taken over as his MO by that time.

Q. Okay. So she's authored this document. And she does "History of Present Illness, Release Medical, Infantryman, Tour Afghanistan ..." et cetera, et cetera. Then it says: "PCat submitted 2013/02/26." What do you understand that to mean, that reference, PCat submitted February 26, 2013?

A. Okay. A little bit of a preamble here. All military members have something called a permanent category. Like everyone has to have one, like, and normally ... like I don't know how they choose the numbers. But, normally, it would be G2O2. And the "G" is geographic and the "O" is operational. And so if there's no limitations, they're G2O2.

If they've had PTSD and recovered and ready for full duties, they would get G3O2. And all that the "G3" means is that if ever they were to be deployed, they wouldn't just have the predeployment screening by psychosocial team, they would also have to have it run by their MO to make sure the MO didn't know of any reason they could not be deployed.

And if somebody is unable to do their regular duties, then they got to sign a temporary medical category. That's what the "TCat" is. And then the "G" numbers and the "O" numbers are higher. And something like a "G4" would probably mean they had to see a specialist more than every six months. And the "O" might typically be something like unfit for operational deployment or cannot do shift work or something like that. It would mean they are not able to do their regular job, that would be the operational restrictions.

Q. Okay. So when we read, PCat submitted February 26, 2013, does that mean that the medical officer was suggesting he should be going to a permanent medical category or just that there would have been a change in his ...

A. There would have been a change. And so if she thought, at the time, that he was ready to go ... to start going back to duties, maybe they would have given him a PCat of G3O2. I don't know. But, on the other hand, if the person had reason to believe that, no, he probably would never go back to full duties, then they'd give him a PCat code that indicated a recommendation for medical release. And usually when they do that, they submit a document that goes to the base surgeon, the chief doctor, and then that document gets sent to Ottawa. And

there's ... so it's a bureaucratic process that takes time.

Q. Okay. Thank you for your clarification of that. Because we know, from the documents, that in April of 2014, is when it looks like the paperwork you just described for the permanent medical category is escalated up. So I was curious about this reference just days ...

A. Oh! Okay.

Q. ... after you've seen him, to indicate that, you know, he might be ready to come off that temporary category. But that helps give us some framework of that. Thank you.

A. Yeah. Because I don't really ... I'm not aware of what document was submitted.

Q. There are two more questions in Exhibit 242 that I wanted just to review with you, if you have any ability to share with us. On that same page under the "History", there's a note that says, "Currently in marital counseling. Civil side by himself." So this is from May of 2015. He's ... we know he's medically released from the military in June. What would you take that to mean from your understanding of these types of medical Canadian Forces documents, Dr. Rogers?

A. Well, it meant that he was seeking some help for his marriage difficulties but they weren't doing it as a couple.

And it sounds like he was paying for it out of his own pocket. Because, yeah, I don't ... it doesn't really quite hold together. You could have marriage counseling on your own, but he might have sought help, wondering, you know, What can I do to improve my marriage?

Q. And you ... from the civil ... the reference to "civil side by himself", that would suggest to you that that would not have taken place within the Canadian Armed Forces medical system that he would have accessed that kind of counseling or assistance for his marriage?

A. Yeah. I mean because if a psychosocial team for ... if their caseloads were heavy enough that they couldn't take him on, they could have referred him out or he could have just decided to do that on his own.

Q. Okay. Thank you. My last question for you on this document, it's on the bottom of the second page under what we see entitled as a heading "Plan". And it says: "Referred to BAC. Urgent due to impending release date." Do you know what "BAC" means? Do you have any idea what that ...

A. Base addiction counsellor. So there must have been some reason to believe that he was using, you know, typically more alcohol than he ever used to and so they'd want to make

sure they got that assessed before he left.

Q. Okay. Thank you. And we've seen that document. I just wasn't clear what "BAC" stood for, so that helps close the lid on that. Thank you.

A. Okay.

Q. You ... at the beginning of your evidence this morning with Mr. Murray, you took us through the mental health program through the OTSSC, the psychosocial stream and the mental health stream. Two things in particular that you told us about. You said there were resources available through that program for children and how to help children cope and also resources for supports. And you talked about a support group. I think there was a group, six sessions, that significant others or spouses could attend.

My understanding from your evidence this morning and certainly your responses to some questions this afternoon is accessing those resources would be predicated on a member providing consent or informing their significant other about them. Is that fair to say?

A. Yes. And, actually, the military doesn't provide services directly to families and children. They'll do it in the context of parents. If they are having difficulty with

their child, the parents would seek counseling and the child would often be present. But the military has another thing. If a spouse needs therapy for any reason, they can do it through the Sun Life plan. And, similarly for children, if a child needs assessment for any reason, it's done that way. It's not done directly by the base services.

Q. Okay. So ...

A. But there was ... there is something called ... it's sort of a combination of the CAF and Veterans Affairs. They have peer support programs. So they have a peer support program for military members. That's off the base and it's run by usually a former military member. And that's for members to support each other. And then they have ... they call it OSISS Peer Family Support, I think. And so there's places for the spouses to contact and get support.

(14:10)

Q. Okay. So when you had talked about resources for children and how to help children cope, that would be accessed through either those peer support programs initiated by either the parent or through the Sun Life private insurance program that military members have coverage in?

A. Yes. And the other thing, I mean the group that I

spoke about, that took place through the Mental Health Centre. It was ...

Q. Right.

A. ... developed and ... by one of our clinical social workers. And that one one of us ... and it was done in conjunction with the Family Military Resource Centre. And one of the sessions was looking at, you know, how we might approach talking about it or helping kids of various ages.

Q. Yes. And as I understand your evidence, for that group, for a spouse to come, the member would have had to have given permission for them to even know about it. Is that correct?

A. Yes. And then we would invite them. But it really would not have been possible for Lionel Desmond's wife to attend because it was one evening a week for six weeks in Oromocto, so ...

Q. Yes. No, I appreciate that distinction. I'm just curious about ... I mean you told us that you have had some clients, Dr. Rogers, whose spouses don't even know they have a PTSD diagnosis and ... or that ...

A. Yes.

Q. ... they're in treatment. So in that kind of a

situation, you know, obviously with the member's consent needed for a spouse to come into the support group, they would never know about it.

A. They would never know. And there's ...

Q. Right. Yeah.

A. You know, there's nothing we can really do about that. Yeah.

Q. Did you get a sense that Lionel hadn't told his wife about his PTSD diagnosis or did you ever have an opportunity to canvass that with him?

A. I don't recall a conversation about it. Like in most cases they do know; in fact, I believe somewhere ... I can't remember where I read but she was the one who encouraged him to seek help. So he would have ... she would have known that he went through his medical officer and got referred. And presumably ... well, Dr. Joshi would have asked if he could invite his wife to part of the assessment. I don't know whether that happened.

Q. And similarly on that, you ... collateral information from family members such as a spouse are helpful, I would put to you, in terms of treating PTSD. That's correct?

A. Yes. It's really helpful because if ... you know,

sometimes the spouses feel really isolated, you know, because, you know, their other friends their own age may not have those kind of problems in their marriage and they feel alone and they might lack information. And some wives, you know, they've done a lot of reading about it. And in Mrs. Desmond's case, she was a nurse. She may have known about it because of the work she did. But, anyway, she never called. Like sometimes, you know, somebody would call an MO or Dr. Joshi or me and say ... and express a wish to come in and talk to us but that never happened.

Q. And I appreciate that didn't happen. But if that had happened, if a spouse or significant other reaches out to you or someone on the team, are you able to start talking to them or do you have to then go get permission ... or first, rather, get permission from the member to even have that conversation?

A. Exactly. Yeah, we have to have permission. I've had ... I mean I remember once when someone's spouse just left me a voicemail. But before I could even respond to it, I had to clear it with the client that it was okay to speak to her.

Q. And from your evidence, it appears that you addressed with Cpl. Desmond speaking to his wife. But he identified the geography and the fact that she was busy in school as a barrier

to being able to communicate with her. Did you ever get a sense that he was ... or did he ever give you ... sorry. Did he ever prohibit you from calling her or it was more about like he just felt like with the distance and the time constraints of her university program, it would be difficult to reach her during the house of the clinic?

A. Yeah. We never talked about phone calls, as I recall, but I had hoped that perhaps on, you know, something like a reading week or something she might be able to, when she was visiting him, come in and see me. But, you know, I don't even have any evidence whether or not he discussed it with her. I suggest that I asked him to.

Q. Okay. Thank you. And my last question is sort of a reflective question but it's based, Dr. Rogers, certainly on your extensive experience assessing and treating PTSD. And it's ... you know, looking back now, you've spent a lot of time obviously in your career dealing with the impact of combat trauma on veterans and military members that manifested in PTSD.

Is there anything that you can share with us as suggestions that you think that can be done to prevent or mitigate against or minimize for soldiers going into combat the likelihood of developing PTSD?

A. Well, a lot of the soldiers are very young and maybe haven't encountered severe adversity before, but the military actually recognized a need for that when they saw the fallout from Afghanistan. And the senior social worker for the Forces in Canada, she spearheaded the development of a program to develop mental resilience. It's called R2MR. It stands for "Road to Mental Readiness". And it's even an app. You can get the free app on your phone or your tablet. And it teaches different skills, everything from the tactical breathing to checking yourself for problematic thoughts, all sorts of different suggestions to increase your resilience to stress.

Now that had not been developed, I don't believe, at the time I saw Cpl. Desmond, but it was probably in development. I could actually find out when it began but now it's routine. All military members get that training. Their leadership gets the training. There's sort of a small department responsible for going out and providing that education to everybody.

Q. And how long is that training, Dr. Rogers, to your understanding, that currently exists?

A. That, I don't know. I don't know whether it's like a full day. Again, I could even check this afternoon. I happen to know somebody who is involved in the training. That's his

job. But, typically, it would be at least a day and for the military members perhaps longer. I don't know.

Q. Outside of that R2MR Program, Road to Mental Readiness Program, anything else that ...

A. No.

Q. ... you can offer by way of suggestion and advice, given your extensive experience and expertise in this area that you think would be of value to try to prepare military members for combat from a mental health standpoint to avoid the legacy of PTSD?

A. Well, I mean, they can't really imagine every scenario, but I know in the training for ... their predeployment training, they are asked to rehearse extensively various scenarios. Like if you're in a convoy and a vehicle gets hit, this is what you do, and they practice it. And they go through it in their imagination and, as much as possible, physically until it's almost as automatic as breathing. And so they have drills for all kinds of things.

They're kind of trained to imagine the worst that could happen and what you could do. So they have training for preventing danger. Some of the people in Special Forces even get training in simulated capture, so I think it's called ... I

can't recall the name of it but they go through a simulation as if they were captured even from, you know, having hoods over their heads or chains. And they have to practice being prepared for things like that to happen. So I know depending on what they're going to go through, they get a lot of experience.

But I don't know whether anything can really prepare someone for seeing a dismembered body with masses of flies. Like it's hard wired into us to feel disgust and horror at the sight of body parts or severe injury. So, you know, the skills in the Road to Mental Readiness would certainly help. They would help with things like false self blame or even coping with the physical reactions. But emotionally, existentially, you can read about it in a novel, you could see a video about it, but it's pretty difficult when you're faced with it.

(14:20)

Q. Thank you, Dr. Rogers. Those are all my questions. Maybe we'll work with counsel for Canadian Armed Forces to get more details on the R2MR Programs. So you don't have to worry about doing that right now. Thank you.

A. Okay. Good.

Q. Appreciate your time. Thank you.

A. Yeah.

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

MR. RODGERS: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. RODGERS

(14:21)

MR. RODGERS: Good afternoon, Dr. Rogers.

A. Good afternoon.

Q. All right. I'm Adam Rodgers, different spelling. I spell mine with a "d". I'm counsel to the ...

A. Okay.

Q. ... personal representative of Cpl. Lionel Desmond. So I have a number of questions for you, as well, building on some of what you've already answered. And I appreciate you taking the time here today.

Dr. Rogers, I just maybe start asking about the prevalence of PTSD among combat veterans. It's my understanding that among troops that have been discharged for medical reasons, that PTSD is the most prevalent of those ... of causes for that kind of discharge. Is that your understanding, as well, or is that a fair comment?

A. I don't know about the statistics for people who have been discharged but I certainly know that the most common

disorder that we treated was actually depression. I mean certainly PTSD ... there were certain cohorts like on ... at CFB Gagetown, we actually had a research study where we got as many people as possible from the 2007 ... one of the tours in 2007 and we did look into things like the prevalence of PTSD. And it varied a lot by trade. And if my memory serves me right, the people who did the bomb disposal, like the EOD, they had a very high rate. It was something like 40 percent. But not all trades had a similarly high rate.

Q. So you'd agree though, Doctor, that it's ... you know, there's going to be future combat missions and so getting this right, treating/identifying PTSD is still an important goal of the Armed Forces and those supporting our troops?

A. Yes, very much so. That's why they work hard to reduce the stigma, educate the whole chain of command on how to look for things. Like I believe part of the R2MR for the leadership is to not only be aware of your own mental status but to look for signs in the people that report to you.

I recall one of the things is this diagram with green, yellow, and red. And that's to look at the signs like you're okay, that's the green. Here's some signs with thoughts, behaviours, and feelings. It may be you're getting into the

yellow. And then, you know, recommendations. And then if you find yourself in the red, then go seek help immediately. So they didn't just urge people to get help but they taught them how to recognize when they needed it.

Q. Well, that makes sense, Dr. Rogers. As you, I think, testified before, and we heard from Dr. Joshi yesterday, that sometimes the people around the individual that recognize those symptoms in advance and not the individual themselves.

A. Yes, that's true. I've had, you know, many people tell me that, I thought I was fine, maybe a little edgy, but I didn't see anything wrong. And it might be, you know, a family member or spouse or even kids that would notice. Like people that were hypervigilant, they would notice that, or somebody who thrashed around in the bed when they were having dreams.

Q. I take it from the whole of your evidence, Dr. Rogers, and just looking at your CV where you continue to go to conferences and educate yourself on PTSD that you would think that there's still more to learn and more refining to do in terms of treatment and identification of PTSD.

A. Yes. There's always more to learn because PTSD affects the person and their whole milieu. And there's a lot of factors that go into predicting whether someone will develop

PTSD. And there's a lot of factors that predict prognosis that help give you a feel for whether the person will make a good recovery. And we're still learning more about that. More treatments are being developed. There's certainly a lot of emphasis now on things that have been incorporated into Road to Mental Readiness, the importance of mindfulness, just being aware of your own feelings and thoughts. And that's a part of the evidence-based therapies, too. But there's research always being done.

Q. It seems that this tool you're talking about, Road to Mental Readiness tool, may be something that's quite valuable and certainly something where further research and input would be appropriate, would you say?

A. I would imagine so. Well, I think they've developed it and they refine it as things ... as time goes on. But I don't know whether they've made any recent changes.

Q. Just thinking of that for a moment, Dr. Rogers. We talk about or you've talked about exposure therapy and how that's done and I want to ask you a little bit more about that. But is that the line of thinking that you have in terms of prior to combat and making a soldier ready for it, some kind of exposure to the trauma that they may be facing when they're in

combat?

A. I don't know. I mean there's just so many different possibilities that I don't know whether that would help or whether it would sensitize somebody.

Q. Yeah.

A. But certainly they're aware that they're going to see people killed. They're aware that they may have to kill people. And it's not an easy thing to train someone to kill. Most ... the vast majority of human beings are very reluctant to do it.

Q. And that's a question I had, as well, Dr. Rogers. It seems that there's two sides of the PTSD question; one being, perhaps in General Dallaire's case, things that he saw ... well, I guess his crosses into both categories, but things that he saw that he can't get out of his mind or things a person has seen/witnessed and then, on the other hand, things that a person has done ...

A. Yes.

Q. ... and that it ... there's a moral injury there or some undermining of one's moral being. And are those ...

A. That's right. It's a perpetration.

Q. And so are those ...

A. Yeah.

Q. ... distinct in your treatment and your thinking in terms of how you approach those in an individual?

A. Well, I mean I know there's some researchers like Brett Litz and ... I can't remember the other person's name, but there's a few people that look at moral injury. And some of them see it as separate from PTSD. But it's those kind of beliefs like, I'm a bad person because I killed somebody, or, I killed someone and it turned out to be, you know, an innocent farmer not a soldier.

Those are ... those lead to PTSD. They're really challenging for the person because, you're right, it hits their morals, like especially, you know, if somebody is very devout. They're thinking of the first commandment, "Thou Shalt Not Kill". And so it's very troubling and they don't want to let themselves off the hook. But they have to look at the context. Like some of them ... I remember one guy who, because he had killed during the war and he was capable of that, he came back and he said, Oh, I'm a cold-blooded killer. That's how he saw himself.

So, certainly, Cognitive Processing Therapy ... we even had a workshop on how you would use CPT to address those moral injuries. And so you would look at ... in the same way that,

you know, most people know the difference between manslaughter, second-degree murder, and first-degree murder. Part of it is the intent. Was it an accident, or did you do it on purpose, or did you plan and want to do it, or was it part of your job? I mean you would really look at the whole context. That's very much part of PTSD or prolonged exposure and it certainly would come out in all the evidence-based therapies.

(14:30)

Q. Yeah, you really need to contextualize it for them or make sure that they understand the context in which they've committed those acts and it's different ...

A. Yeah.

Q. ... from the world that we entered.

A. Yeah. And there was one specific modification suggested by Brett Litz and I think it was Marie Steinbrenner and another guy whose name I can't remember, and they suggested specifically getting the person to imagine a mentor, somebody they respected. Maybe a boss or a parent or uncle, someone whose opinion they respected, and to imagine that person what they would say to you. Would you blame you as harshly or would they be able to help you put it into context? And so there's different little tweaks you can make to any of the evidence-

based therapies to incorporate ... to help someone come to terms with moral injury.

Q. It's interesting that you make that connection to an individual the person respects or can speak with from their own life rather than a clinician or a professional in some other context.

A. Yeah.

Q. Dr. Rogers, I want to switch topics just slightly here and talk about treatment in terms of timeliness, and get into a little bit of the question of the stigma of PTSD.

When I review the American Psychological Association Clinical Practice, and I'm sure there are Canadian equivalents which I could have researched as well, but they talk about the post-traumatic reactions manifesting themselves nearly, you know, almost immediately. Like certainly within days and in the early weeks and months after an incident.

So, I guess my question is surrounding the time when combat troops return from combat, return to Canada, and what happens at that point. The question is, I guess, do you see a role there for intervention from yourself and your colleagues in terms of broad-based intervention rather than, say, waiting for either an individual or somebody close to one of the soldiers to report

them, seek help on their behalf?

A. Mm-hmm.

Q. Would you think that ... you know, a broad-based, everybody gets this approach might de-stigmatize and help identify some of those symptoms early on?

A. Well, certainly for quite a long period when somebody finished their deployment they didn't go straight home, they had a few days in Cypress, and they were given information and signs to look for and some coping. I don't know exactly what was involved but that happened immediately after deployment. And then when people got back within three to six months they had a post-deployment screening. So somebody would interview them and ask specifically about those kind of symptoms.

Now that would identify some people for sure, but it wasn't anonymous so anybody who had fears about their career might minimize their symptoms and not get picked up. But even moreso, there can be delayed onset of PTSD. Because when you first get home, you know, a lot of people are so happy to be home. They're happy they survived. They're glad to see their family again and they get some time off to relax. And so that can be a good time and they're given that time so that they come down from the experience.

And so for most people if they have that opportunity to relax they might have their memories and feel some of the emotions that came with the traumatic memories but they wouldn't have other responsibilities so that would just die down naturally over time.

You're more likely to get problems if you immediately get deployed or posted somewhere else, so say you have to worry about moving and finding schools for the kids and learning a new job, those kind of upheavals can get in the way, but sometimes people just develop the symptoms later. Like they might be fine for a few years and then something will remind them. Like say a buddy of theirs was overseas and got killed and that would bring all the memories back. So there's definitely delayed onset.

In fact, I mean, sometimes I've been told that Veterans Affairs gets the occasional person from World War II who needs help. I've never seen that myself. But, you know, in the States it's quite common for Vietnam veterans to still be coming forward. And we certainly ... we've still got the occasional person from Rwanda and that was ... you know, when I was there it would have been 20-plus years ago, and Bosnia.

Q. I want to come back to that question in a moment, Dr. Rogers. Just thinking in terms of Cpl. Desmond, his post-

deployment screening suggested that he had a hard time in Afghanistan and had a hard time dealing with some of the things he saw there. So even without the benefit of anonymity he identified that right away, I guess.

The question is would you ... we're trying to be forward-thinking here in how we address these issues. Would you see a benefit in keeping a group of soldiers together for a longer period of time after they return? I mean, we hear they're training for a year beforehand, then they spend three days in Cypress as you said, this is what Cpl. Desmond and his group did, and then come home and everybody goes their separate ways.

Would you see benefits I keeping them together for a period of time afterwards to allow some of that processing and, you know, decompression to take place in a less stressful environment?

A. Yeah, I mean, certainly when they have their post-deployment leave, like I think it's at least a month, and some of them spontaneously keep in touch but it sounds like you're talking about something more structured where they ... Yeah. I don't know ...

Q. Something ... yeah, something more structured ...

A. ... I mean certainly ... Yeah. Yeah, that I don't

know. I don't know whether people have considered that. Certainly it's really difficult if you immediately get sent somewhere else ...

Q. Yeah.

A. ... you may be too busy to really process it. And yet for things like traumatic events and grief, like there's a lot of variation from person to person. I know of someone whose sister died in an accident very young and she could have had help at the time, didn't take it, and she carried on as usual. It was about a year later when she had a close call on an accident and that's when she began to grieve. And so ... and it worked for her; she was functional, I don't believe she needed any therapy. But people react in different ways and it's hard to predict.

Q. Yeah.

A. Some people would probably not want to be coerced into some kind of group therapy if they didn't need it or even group activities if they didn't need it.

Q. Just backing up for a moment. You mentioned the different combat situations, Bosnia, Somalia, there's, you know, others, East Timor and other locations, in your experience does it make a difference or impact your treatments in terms of

whether the mission itself has a clearer moral purpose or outcome in the minds of the soldiers?

Does that appear to make a major difference in terms of whether it's the volume or severity of cases of PTSD?

A. It may. I mean, because most of them join because they wanted to be of service and most of them believed in the missions they were sent to work on. And some people became disillusioned thinking, Oh, you know, why were we there, and it's a tough call because sometimes in the short term you don't know.

I think it was probably a lot clearer in World War II because, you know, people went over with the idea of defeating Hitler and that's what happened and so people tended to feel good about it when they came back but it still didn't stop them from having PTSD.

(14:40)

Q. Yeah. No, I was thinking of the US examples in particular, you know, the Vietnam War versus the Korean War and the controversies over Vietnam, for example. But anyway, that ... if it's not a significant clinical question in your view, I don't want to dwell on it.

A. Well, it is in a way because the thing about the

similarity between Vietnam and, say, Somalia, when the soldiers came back instead of people cheering and saying thank you for their service there was a lot of sentiment against it. And so that would be really hard if you already were suffering from post-traumatic stress symptoms and people were hostile toward you, you'd feel even worse. There's no doubt about it, psychosocial stressors and the environment you return to has an effect.

Q. Well, so it would seem then important that there be or at least be understood to be a clear mission and a clear purpose to the mission?

A. Yes, and a lot of them really believed that. Like some of them would say, Well, I want to make sure that we build schools for girls or that to make sure that they can go to school or to, you know, they were very focussed on fighting back the Taliban, so most of them went there with a very clear sense of purpose.

Q. I'm going to switch topics again just slightly, Doctor, and talk again a little more about exposure therapy. The question for you is going to be how scalable the expertise might be. And one of the reasons I ask is we've all looked at your resume, your *CV*, and you're very qualified, you've been

well educated in all that, but that may not be the case for everybody at all times. And, in fact, it may be desirable to disperse the expertise even more widely if there are ... you know, to treat more individuals with PTSD.

I guess the question is how scalable is that kind of expertise? The exposure therapy, the therapy that you conduct with veterans, is that something ... how qualified might a person need be in order to do that?

A. Well, in the military we ... you know, it really depends on the clinician, if they're motivated to do it and willing. And so we've had ... I mean, some of our clinical social workers they got their training, some of it at their own expense and time, and so somebody motivated, who has a sufficient mental health background. Well, we had some wonderful clinical social workers and more recently I know of at least two of the nurses who trained in Cognitive Processing Therapy and they're amazing therapists. Like it was wonderful to work with them.

And so, yeah, you don't always have to have a doctor to treat people with PTSD. And there's a big ... there's a movement of some psychologists to make general practitioners, like health practitioners of all kinds, whether it's

physiotherapists or general family doctors in civvy land, to be trauma aware. So that's what they really call it is becoming trauma aware.

And so even doing things like screening, asking, you know, if they'd been subject to any kind of physical, sexual or emotional abuse as kids or had they been bullied, just to at least screen for those kind of things. And then to be aware if somebody had, you know, an unusual anxiety that there might be a reason for it.

Q. Well, we've heard actually evidence from two of Cpl. Desmond's sisters, one of whom is a nurse, the other is a continuing care assistant, that they've received that mental health training to be able to identify ...

A. Oh yeah.

Q. ... a situation. So that seems to be ...

A. Yeah.

Q. That seems to be happening in wider circles.

I guess I'm thinking of the treatment side because in many cases, of course, after discharge the veteran will be in the community and interacting with a provincial health system and ... either within the hospital setting or else they'll be getting counselling through a private counsellor.

I'm wondering how widespread or how scalable that expertise might be to that level of caregiver?

A. Yeah, it partly ...

Q. I just wonder if you have thoughts on that.

A. ... depends on the availability of training and certainly now that video training is easily available that's more possible. But then you need ... when you learn a new technique you need some sort of supervision, like feedback about, you know, something you might have missed or something we could do differently. You certainly need some supervision after.

But, I mean, that was certainly part of my desire to get the internship and practicum training done at our base. Because even among psychologists who certainly have the right background, some of them don't realize that they would be able to treat certain populations, like prisoners or military or police, and they do, they just need the opportunity for the training. So that's helped a lot, if there's internships in those kind of settings and those students are aware and they tell their friends.

And I imagine the same thing with social work, clinical social workers have an opportunity to take that kind of training

if they want, if they want (inaudible - audio skip) do it.

Q. Right.

A. In fact, EMDR actually most of the trainers, I believe, are social workers.

Q. Yeah, that seems to be becoming more prevalent, the EMDR training. And so in ... sorry, I'm not ... I did mean to ask you about that but ... So in your view the internship at Gagetown or ... has that worked well, the way you structured it?

A. Yeah, it did because UNB they were, you know, once we had satisfied their requirements they were happy to send us students. So we had advanced doctoral students who did an advanced practicum with us and then we actually had two people do their internship. An internship is the last stage you do before getting your doctorate. And it worked out really well because both of those interns after they graduated, they became two of our external providers, they were really good.

Q. Do you know whether that's taking place in other parts of the country, that internship structuring?

A. I actually don't. Yeah, I don't really know because probably it would be, you know, depending on each base, but certainly for many professionals it's very motivating to train students. Like I find you actually learn a lot by supervising a

student and, I don't know, you kind of get new ideas too.

Q. Sure. Well, it seems ... anyway, it seems like something that might be a recommendation coming out of this, if that's not taking place across the country, a way to break down those jurisdictional barriers that can sometimes arise.

Doctor, I wanted to ask you a little bit, Dr. Rogers, about the potential connection to traumatic brain injury, and you've been asked about this a couple of times already so I'm not going to go too far on it. But we do have other evidence that Cpl. Desmond did suffer concussions, loss of consciousness for about 20 minutes I think in one accident, but three instances that we've heard about, there's some evidence.

A. Hmm.

Q. And I took your evidence from earlier that that probably wouldn't have changed much about your treatment methodologies with him.

Dr. Joshi yesterday said maybe if you knew somebody had a brain injury you might go a little slower with them, but I presume you're assessing how fast you're going to go with any patient in all times in any case. Would that be fair to say?

A. That's true because sometimes you have to modify the treatment. Like if they're doing a session and they're having

difficulty grasping the material, you might do, you know, the session in two parts, like one week apart. But Cpl. Desmond didn't have any trouble grasping the concepts. Like once his depression had alleviated somewhat he had no trouble grasping the concept. He had no trouble going through it. He was able to label his level of distress. He was able to talk about, you know, what he felt and what he thought. And in his care of his daughter it was clear that he was able to organize, so I just didn't see any sign.

(14:50)

Like the impairment and concentration at the beginning, that's typical in depression or PTSD, it doesn't stop someone from responding well to treatment. And things like being able to organize your day or to be self-aware. Like he noticed when he was unable to ... when he had forgotten his weapons drills, he ...

Even in his first session with me he had that nice metaphor to describe how he changed from a happy person to a depressed person, so that indicates a level of abstraction. And he had a dry sense of humour that would come out, so I just did not see any signs of impairment in him.

Q. Maybe not impairment. I'm thinking, Doctor, in terms

of your answer earlier about when he was thinking about his wife or talking about his wife that he had a flat affect or he was unemotional and that seems like it might have a connection to a brain injury sufferer. That sometimes that's a result; that their emotions are flatter than they had been previously.

And what all ...

A. Yes, but I mean it's a prime ... like it's a very prominent PTSD symptom. It's part of the things that you ask for when you're interviewing so ... And for depression as well, you can have depression and no PTSD. You can have depression and no brain injury at all and you're ... you know, you can have a completely unemotional basic flat affect. Actually, there's at least three disorders I could think of where somebody would have a flat affect.

Q. And I understand from the literature as well, that after a number of years it's difficult to, you know, sort of pick out symptoms that might be from PTSD versus brain injury in any event, and so the treatment may flow naturally in the same manner.

A. Yes.

Q. I was wondering if it may also have explained why he was more inclined to record his descriptions of events rather

than write them out in long hand, but if ... I don't know if you have a comment on that.

A. Well, I mean, often it's just a preference. Like it's shorter to say something than to write it and it's probably easier to listen to something rather than to fill out one of the cognitive processing therapy worksheets or to write an impact statement.

Q. Sure. Thinking of those recordings, Dr. Rogers, I understand, and we've been told that those recordings don't exist any longer; that Cpl. Desmond made himself of his own description of his time in Afghanistan. Is that correct that those have been destroyed?

A. That's right. We erase them at the end of the therapy. I mean, if someone has it on their phone we don't really have any control over it, if they wanted to keep them they could, but the ones on the recorders we would destroy them. Destroy the tape. We delete it and then keep it in a secure place.

Q. It's ... you know, for our purposes in this Inquiry, it seems unfortunate that those don't exist any longer. Why do they get destroyed?

A. Well, at the end of therapy the person can listen to

it and not be as distressed and may interpret the event differently so they don't really need it. Like I've had lots of clients in the time they've listened to it often enough they say, Oh, it doesn't really affect me anymore or some people even say they feel a little bored listening to it. So chances are they're ... I can't see any need, it's just, you know, part of the protocol.

And if somebody ever did feel troubled about the same event, I mean, say 15 years later something reminded them then nothing would stop them from making their own recording and listening to it because they would know what to do.

Q. I'm just thinking what about in terms of the historical record or to assist with research into PTSD or combat situations generally? Like could you see how it might be valuable for those purposes?

A. Yes, prolonged exposure is ... has been highly researched over the years by the developers of it, and so they would have had a very rich data set to draw from.

There was Edna Foa and Barbara Rothbaum, I think, they published research in that area for many years. And in doing the research, they would have kept the recordings and probably, you know, done some, you know, analysis of them.

Q. You ...

A. Oh, did I ...

MR. RODGERS: What did I do?

A. Did my video go off?

THE CLERK: Yes.

MR. RODGERS: I can't see you, Dr. Rodgers. I can hear you. There we go, I can see you again.

A. Can you see me now? Oh, can you see me now?

Q. Not now.

A. I don't know, this is bizarre.

Q. I can ...

A. Camera on.

Q. There we go, I can see you ...

A. Can you see me?

Q. ... and hear you perfectly clear now.

THE COURT: Yes.

MR. RODGERS: Yes.

A. I don't know what happened.

Q. No, that's fine, we're back.

So just a few more questions, Doctor.

When you noted that Cpl. Desmond was able to do weapons training like towards the end of your treatment of him, and I

guess the question ... I'm thinking of this in terms again of exposure therapy, if you saw that as a good thing for him to be able to put a gun in his hand, go to the range and experience that again. Experience that sensation if nothing else. Is that therapeutic in some way?

A. Yeah, when somebody's ready to start returning to .. you know, approaching their full duties again, yeah, it's useful for them to be able to get in and out of military vehicles or handle weapons or go through simulation, because they really need to. If they want to go back to full duties, they need to be able to do those things.

Q. And what about activities such as, you know, going hunting with your friends from the military, hanging out in that kind of a situation, is that something that's been considered or looked at in terms of PTSD therapy?

A. I don't know whether anybody has studied it. I know from experiences of my clients, if they have some buddies that are friends of theirs it's ... I mean, they sense that it's therapeutic to go out with their friends and go hunting. Sometimes they don't even care if they get a deer or a partridge, it's just the fun of being with friends, I guess, who have gone through similar experiences, they understand each

other.

Q. Yeah. And you have the outdoors, nature, you've got the weapon in your hand again so you're ... there seems to be some therapeutic value in that respect. Of course there's a risk too with anybody with a firearm would naturally carry with them but does that strike you as ...

A. Well, not necessarily because it's a context again. Because in a war situation you've got a gun and your intention is to defend yourself or seek out and kill an enemy if necessary. If you've got a gun you're not thinking about people, you're out hunting a deer or a partridge.

Q. Yeah. All right, Doctor, and you've ... I wanted to ask you, you had successfully gone through therapy with Cpl. Desmond and he was seeing some good results or you were seeing some good results in him, but then it seemed that that was undermined afterwards by some different events and it seems that the racial incident at work was one of them and perhaps family discord being the other main one that you thought of?

A. Yes, even though I wasn't seeing him by then, it's certainly true that those two things they were significant stressors and he did not seem able to cope with the racial comments, yeah.

(15:00)

Q. What about ... I'm wondering ... and you can answer about Cpl. Desmond or more generally, but is dealing with the bureaucracy on their own, trying to get their benefits straightened away or move on to the next assignment or educational pursuits, does that kind of activity sometimes undermine successful therapy or re-trigger? Could that be considered a triggering incident or a triggering activity?

A. I don't know so much about triggering, but it can be frustrating ...

Q. Frustrating, yeah.

A. ... and that's why the military put ... there's a group of case managers and they're usually nurses with mental health background and they help the clients negotiate all that stuff. They'll say, Okay, you have to fill out these forms, or, You have to do this and here's how you get vocational training. And they kind of walk them through it and they sort of advocate for them if something ... you know, if there's a form that needs to be filled and no one's given it to them they make sure the person knows what to do and when to do it and even how to do it and ...

Q. So I presume as a clinician you would find that role

to be an important one in supporting ...

A. Oh, yes.

Q. ... a veteran through their recovery and their treatment.

A. Yes.

Q. Dr. Rogers, we have some evidence from the days just prior to and of the tragedy itself of Cpl. Desmond making appointments into the future for treatment. He was looking for houses. He had returned a pair of boots. He had ... was looking into gym memberships. Do you have any comment on that seeming contradiction of making those forward-planning kind of moves but then doing what he ended up doing on January 3rd, 2017?

A. Yeah. Well, I mean there's a couple of possibilities. One would be ambivalence because typically someone who is even planning suicide, far less murder, would have some amount of ambivalence about it. And so sometimes people could make future plans as sort of an attempt to stop themselves from carrying things out.

And another possibility was of someone who has decided to do such a thing in order to carry it out. They have to make sure that nobody guesses what they're thinking, and they can be

very good at hiding it. I mean I recall a really prominent example of that when I was in graduate school. There was a student a couple of years behind me and on the outside everything looked wonderful. Like he had a Masters degree in music. He was a very accomplished person and he was surrounded by people that would have helped him and could have gotten him top help.

But what we did not know is he had serious suicidal thoughts and it had been happening for months. And one day, you know, he agreed to meet his wife one evening. They were in a production and they were meeting at a rehearsal and he didn't show up. And it turned out he had driven off into the countryside and killed himself by carbon monoxide. And his wife didn't know. It was not until, like, they kind of broke the code on the passwords on his computer and found things he had written about and found some stuff that he was reading about suicide.

So if someone's determined to do it, and they've made up their mind, they can hide it from other people. And that's the dilemma that we're in. We can ask the right questions. We can use the right predictions. We can do our best, we can have a relationship with a person, and sometimes our best isn't good

enough and that's really ... it's hard. You have to accept that if you're going to work with people that have the potential for suicide.

This is the first time I've ever ... I had ever worked with someone who eventually committed murder, but ... so you tend not to think about that as much. You just do your best and ...

Q. And, Doctor, just on that. I'm going to ask you how you handle that personally.

A. It's difficult. I know when I was first doing a lot of clinical work with suicidal people I remember having this mental image of handcuffing someone to my wrist and it was just that mental image. And I thought, Okay, Wendy, you know that doesn't make any sense, you want to help them, you want them to be safe, you cannot police somebody 24/7. You can do your best to give them the skills to cope with painful emotions, to think about reasons for living or other solutions to their problems.

We try to teach people suicide is a permanent solution to a temporary problem. All those kind of things. But the bottom line, we do not have control, nor should we have control, over our clients. And so if you love this kind of work, and most of the time you get good outcomes, you still have to accept the fact that sometimes no matter what we do, it doesn't work. And

it's hard but you have to accept it.

Q. Well, I'm sure that's very difficult, Dr. Rogers. You do a very important job. So I thank you for that and I thank you for answering these questions today. Those are all the questions I have.

A. Okay. Yeah.

Q. Thank you, Your Honour.

THE COURT: Mr. Hayne?

MR. HAYNE: No questions, Your Honour.

THE COURT: Thank you. Mr. MacKenzie?

MR. MACKENZIE: No questions, Your Honour.

THE COURT: Thank you. Ms. Ward or ...

MS. WARD: Thank you, Your Honour.

CROSS-EXAMINATION BY MS. WARD

(15:07)

MS. WARD: Afternoon, Dr. Rogers. As you know, my name is Lori Ward and I represent the Government of Canada.

A. Okay.

Q. I'm just going to follow up on some of the things that you've already touched on, but before that I just want to clarify something. We've talked about MOs, or medical officers,

and we understand that those are when you're in the military that's what your GP or regular family physician or primary care physician would be called. Is that correct?

A. Yes. Yes.

Q. Yesterday Dr. Joshi talked about a GDMO. Is that the same thing?

A. Yes, it is. GDMO ... the military is full of acronyms. It's general duty medical officer but it's really the same thing.

Q. Okay. Thank you.

A. And not all of them are military officers either. There are some military physicians, but some of them ... you know, there's a few of them, but they could get posted away. But nurse practitioners tend to be there longer, and civilian doctors who work through Calian and they tend to stay longer.

Q. When you say not all of them are military officers do you mean as opposed to non-commissioned members or do you mean as opposed to civilians?

A. Oh, as opposed to civilians.

Q. One of the issues that has come up in this Inquiry is access to medical records. There's been talk of how a person would be able to, or not, access their military medical records.

Can you talk us through that as you understand it?

A. As far as I know, the medical record ... it's kept by the military but I think technically it might be considered to belong to the member and they have the perfect right to see any part of it or to have copies of it. And I have known military members who got a copy of their entire medical record and even made a Xerox copy of it or electronic, as the case may be, so that they would always have it if they need it.

So they have the right to look at any of our notes or assessments.

Q. And do you know how they would go about doing that once they're released from the CAF or Canadian Armed Forces?

A. As far as I know, they would submit a written request to the medical records department.

(15:10)

Q. Okay. Thank you. I don't want to belabour the issue but, you know, there's been a lot of talk about potential head injuries and ... or brain trauma. And we talked about some indicators that would indicate someone had a brain trauma or a cognitive deficit. But ...

A. Mmm.

Q. And you talked with Mr. Rodgers just now about some of

the things that seemed to indicate to you that Mr. Desmond did not have cognitive deficits. And I wondered if you had anything to add. I mean you mentioned his ability to grasp the concepts and you mentioned his sense of humour. Are there any other indicators that he, in fact, did not have a brain trauma?

A. Yeah. I mean I don't recall him ever having trouble with memory. Like, sometimes ... you know, one symptom of PTSD can be that they might forget something about the event, like a person's name or something, but they certainly remember the thing as a whole. And that happens often in PTSD just due to the nature of what they witnessed or experienced.

But typically, it would be things like if people forgot a lot of appointments or if they were leaving stuff on the stove or ... and I mean there's numerous causes. It could ... for something like that it could be substance abuse or distraction because of thinking about something else. But brain injury, usually it would show up, and if it had happened during tour, then somebody would likely have noticed that the person's competence changed. And as far as I know, there was never any question about his competence.

Even something like him working in the band. I mean in terms of motor control, you have to have a very fine sense of

timing and motor control to play the drums and so I just can't think of anything that would be suggestive, even like in that first note where I think it was Adam Rodgers. I talked about how the abstraction, making that comparison to Tigger turning into Eeyore.

And so there was just nothing that I knew of that would suggest to me an impairment.

Q. Okay. Thank you.

You mentioned the spousal group that met at the OTSSC and, in fact, Dr. Joshi mentioned that group yesterday. And you talked about the fact that Mr. Desmond's wife was far away and maybe not available and that he had not expressed an interest in her participating.

I'm not sure if you're aware. Dr. Joshi told us yesterday that he did meet with Mr. Desmond's mother a handful of times and I don't know if you knew about that.

A. No, I certainly don't recall it. I might have been aware at the time but I don't remember.

Q. And is that ... would that group be open to other family members? Like, say, a person, say a CAF member didn't have a spouse, could they sort of suggest, you know, the participation of another family member? I mean his mother met

with Dr. Joshi but what about sisters or siblings?

A. Yeah, if somebody expressed an interest. I'm pretty sure that happened from time to time. The person to ask would be someone who no longer works at the base, Petra Sherman Smith, she's a retired clinical social worker and she was the one that put it together and ran that group many times over the years, and so she would know.

But it seems to me that once in a while if somebody wasn't married or the spouse wasn't available someone else could come. I mean it could be an aunt or an uncle or a friend, but typically, it would be the spouse.

Q. Okay, so we're aware of the difficulties with Mr. Desmond's spouse being in Nova Scotia but were you aware, then, did he, to your knowledge, express an interest in any other family member participating in that group?

A. No.

Q. It's been suggested by some witnesses that when a CAF member has a diagnosis such as PTSD that there ought to be an initiative where the CAF would reach out to that person's family members sort of automatically to discuss treatment and care plans. Can you comment on that idea?

A. We would not be allowed to because at the beginning of

assessment and treatment we actually tell the person that we're obliged to keep everything that they say confidential unless they give us permission or unless certain conditions, like danger to themselves or others or if a court requested the file. There's a few situations we have to tell when we can break confidentiality, but otherwise we promise not to, that everything that's said stays on the medical record and that's it. Like team meeting discussions are okay but really on a need-to-know basis.

So we would not be allowed to, you know, find out the family's names and phone numbers and give them a call. That would have to be done only with written consent of the military member.

Q. So following on that, you know, sort of consent issue, it's been expressed here at this Inquiry and in the media, I think, that Mr. Desmond was allowed to, for instance, leave his in-patient treatment in Montreal early.

A. Mmm.

Q. Can you comment on, you know, a mental health client being allowed to make treatment decisions maybe against advice?

A. Well, yeah, I mean there's a whole procedure for that, any in-patient facility, unless you have documentation to prove

that they are a danger to themselves or others, you cannot confine them and if somebody leaves against medical advice I think they sign it and it's a procedure, leaving without ... leaving against medical advice. You can't stop them. You can recommend, you can persuade, but in the end if they say, No, thanks, then ... and it does happen occasionally.

Q. Okay. I want to turn to the subject of weapons for a minute. Again, it's been expressed to this Inquiry that a person such as Mr. Desmond or, in fact, anyone with a mental health diagnosis, should not be allowed to have possession of a firearm. Can you comment on that suggestion?

A. That, to me, seems very extreme because mental health diagnoses are quite common. Like, I mean for a common example, flying phobia, I think one out of six adults has it. So technically, it's a DSM-V diagnosis and you couldn't say that, Gee, if you have this you shouldn't have a firearm.

Same thing with depression. Like the decision about whether someone should or should not have a firearm would be dependent on looking at typical risk factors.

Q. And what if we confined it strictly to PTSD diagnosis? Would your answer be different?

A. No, it would be the same because I treated and

assessed many people with post-traumatic stress over the years and a lot of them enjoyed recreational hunting or skeet shooting. They ... you know, to them a weapon was like a skill that they had that they developed and they enjoyed being able to hit targets at the range or they liked to go hunting with their friends and bring home a deer or a moose for the freezer. Like there's ... it would not be reasonable to deny someone the right to do those things.

Q. So we've talked a bit about with Dr. Joshi yesterday and with you about MELs, medical employment limitations.

A. Yeah.

Q. What exactly are they and what's their purpose?

(15:20)

A. The purpose of those things was for the medical officer to be able to communicate to the member's chain of command what they were and were not capable of doing and so, you know, if they had a whole list ... like at any time a military leader has to know what percentage of ... or what proportion of their members are deployable.

And so by looking at the TCat versus PCat they would know right away. Anyone who's G202 you could deploy them tomorrow. If they had some other category you could not necessarily. The

medical limitations, they're important when somebody does have a temporary category especially because there's all kinds of things. Like the medical officer has to give specific information. They're not allowed to divulge diagnosis but they have to give specific information. So if someone has a ... a bad shoulder injury the medical limitation might be, Cannot lift anything more than ten pounds above shoulder-height, or, No ruck march. Because a ruck march means you carry a heavy pack and a weapon and you have to walk 13 kilometres in a certain timeframe.

So they ... I remember one of our base surgeons spent a lot of time educating the medical officers on how to write useful MELs and so, you know, for a depressed person who's in the early stages of treatment he might recommend against shift work. And for somebody who had PTSD from an exploding device it would say, No handling of explosive devices.

And so you just try to give something that would give the person's supervisor information about what the person is able to do and not do in their job.

Q. So we understand that Mr. Desmond, or Cpl. Desmond at the time, had an MEL related to personal weapons. He was not to have a personal weapon in the military. What does that mean, if

anything, for his weapons that he might have had at home, his civilian weapons if you will?

A. I'm not totally clear on that, but as far as I know, like no weapons means the weapons that they would have as part of their military duties, the Forces would have no way of knowing what somebody had at home, and I'm not sure that they would even have the right to forbid someone to have a weapon at home.

If we knew they were a danger to themselves or others we'd certainly ... and we knew they had a weapon we'd encourage them to take it elsewhere or have it out of the way. But in the ordinary course of events ... like it's almost standard if someone has PTSD. It's a common MEL to have is no use of weapons at the military. But it doesn't necessarily mean that the person is unsafe with weapons.

Q. So I think that we're having some trouble in this Inquiry with a confusion or a perceived disconnect between a person having a diagnosis that leads to an MEL that says they're not to handle weapons and reconciling that with the person still being allowed to possess a firearm for hunting or shooting.

There's a perceived ... like I said, a perceived disconnect there. Is that incongruous to you or can you reconcile those

two things?

A. Well, it could make sense to me, like, if somebody had post-traumatic stress and say they ... their trade was artillery or even a mat. engineer and perhaps being exposed to those kind of weapons and the line of work would trigger a lot of distress early on. Like, some of those, you know, big weapons like C9s or artillery weapons, they would experience distress, perhaps, handling those.

But the context is so different if they had a hunting rifle and were out for the weekend with their friends. So it might be as much for protection of distress as well as just a general precaution.

Q. So to put this MEL on someone's temporary category, would that necessarily mean you should be calling the civil authorities and having those firearms taken away out of the house then?

A. I don't believe they would ever do that. I mean first of all, they wouldn't know what weapons they had unless a person divulged it. But you would only do that if you had reason to believe that there was an imminent danger of that person harming somebody else and so then you would have a duty to take action, a duty to warn, and a release from confidentiality.

But if you did not have that ... I mean they didn't police that. They didn't go around inspecting the homes of people with PTSD to make sure they didn't have a weapon. It just would be unworkable and not necessary.

Q. Thank you. Just a few more things. We talked a bit ... or it was mentioned yesterday with Dr. Joshi about a JPSU, a joint personal support unit now known as a transition centre or transition unit as we understand. Does a JPSU, or did a JPSU at the time or now, was it a care-giving entity or what was it in your understanding?

A. It was an administrative place. It was like a ... like, every military member has to be a member of a unit, but if they're not able to go back to their old trade, then it usually doesn't make sense for them to be part of that unit. Because instead of the administration being oriented to going on courses or training for deployment the administrative work would be more oriented to making sure they went through the release process properly or that they had access to vocational rehab.

They even had a person at JPSU who coordinated the work placements, and so that's very different from what you would do with the military members still on the unit. So they decided it was better to have that special unit set up to administer to

their new needs, and I know they made a lot of changes to it over the years. I am not aware of what they do over the last two years. But it's not a clinical thing at all. It's all administrative.

Q. Okay. Thank you. When we were talking earlier about services that might be available to spouses, children, or families, you talked about access to counselling and such through the Sun Life private insurer. Would spouses or children, or both, also be eligible for counselling through the Canadian Forces members' assistance program?

A. You know, I actually do not know.

Q. Okay.

A. Yeah. I know at one point the military had little brochures about resources and so it would list different things that the members and their families would have access to. I think that might even be part of the app for R2MR, so that people would always be aware of what resources were available to them.

Q. Thank you. One last area I want to explore. When Mr. Desmond was referred ... or then-Cpl. Desmond was referred to the clinic and his diagnosis, as we understand it, was PTSD and also major depression. Correct?

A. Yeah.

Q. And I think you said that in those circumstances you need to deal with the depression first. Was that correct?

(15:30)

Ai. Some ... yeah, sometimes. Not always. Like it's quite common to ... you know, to take people with a whole array of disorders, even if they have some alcohol abuse, and still give them the treatment right away. But in Cpl. Desmond's case his depression looked severe enough, like with difficulty concentrating at first and like that psychomotor slowing and just anhedonia. Like, sometimes people just aren't really ready yet and they need to get more active, more physically active, and eating better and having their symptoms managed by medication, and that helps them benefit more from therapy than if you tried to start too soon. It's not always an easy call.

Q. So I think that we understand that PTSD is always related to a traumatic event or events over time.

A. Yes.

Q. Are you able to say what his depression was related to, or can depression generally be related to circumstances, or is it organic? I think we're having trouble because we've talked about Mr. Desmond and we've talked extensively about his

PTSD. We haven't talked about his depression really and I'm wondering how intertwined they are or not.

A. They're very intertwined. Like I have this impulse to go like that. Like in the DSM-IV, they didn't incorporate depressive symptoms so much into the criteria, but DSM-V, it's right in there. Like, one of the things was changes in cognition and emotion related to the event. And so, like, it's an existential crisis if you've seen things that we could never have imagined before and you're caught up with the horror of it and you can't forget it. I mean it's ... that tends to make a person less able to feel joy and happiness.

If you've seen a lot of destruction, it's almost like your brain shuts your emotions down because if you feel the good stuff, you'd feel the bad stuff too. It's ... so they're very much intertwined.

Q. And our understanding is that you were essentially engaged for the therapies that would largely treat his PTSD or can you not separate them at all?

A. Oh, it would be both.

Q. Okay.

A. Yeah, you wouldn't separate them because it's really, like, that's one of the most common comorbidities is PTSD plus

depression, and we often get PTSD, depression, and alcohol abuse. They ... you know, it's common to have more than one diagnosis.

Q. So his PTSD was related to his experiences in Afghanistan. correct?

A. Yes, that's ... those are the ones I knew about.

Q. Are you able to say whether, and you may not know this, are you able to say whether he suffered from depression before he went to Afghanistan or did his depression come on at the same time as the PTSD, or from the PTSD, or is it not possible to say?

A. Without looking at the original assessment, that I don't know but, like, if he had a diagnosis of depression, it would be unlikely that he would've been deployed. And certainly, you know, everything he said about himself indicated that beforehand, he was pretty happy-go-lucky and a generally happy person. And that picture that you see so often in the media of him and his wife and baby, Aaliyah, when she was little, they all look very happy. It's not like some pictures. I've seen pictures of PTSD, you know, people with PTSD and they're smiling, but their eyes look really sad, and so you

don't know whether it's genuine. But in those pictures, he looked happy.

After he had died, people that knew him were among my clients and they expressed, you know, grief and shock because they remembered him as the happy guy, the one that would cheer them up with jokes or things like that. Like everything I knew about him from before suggested that he was happy and not depressed before his deployment.

Q. One final question. Is in-patient treatment ... I think it's seen as sort of the Cadillac of treatment. Is it always indicated for severe cases of PTSD?

A. No. We very rarely sent people to the in-patient treatment. We did often for addictions because sometimes, you know, we would need a period of detoxification and then go off to, like, Bellwood or Homewood and things like that, learn techniques to cope. But you wouldn't want someone to be there for long because they have to learn how to manage in the world they live in.

So similarly for in-patient treatments. Like when I was a grad student, people would get admitted to a psychiatric unit and they'd be there for months. Nowadays, that's very rare.

You try to keep it as short as possible. You stabilize them, make sure that you have the right diagnosis and adequate treatment and follow-up and then you get them out to their normal milieu as soon as possible.

Q. Thank you, Dr. Rogers. Those are all my questions.

A. Okay.

THE COURT: Mr. Murray, do you have any follow-up questions?

RE-DIRECT EXAMINATION

(15:37)

MR. MURRAY: Yes, just one. Dr. Rogers, it's Allen Murray. There I am.

I just have one follow-up question from what Ms. Ward asked you. You said that it was kind of a standard MEL for PTSD that members not possess weapons but it didn't necessarily mean that they were a danger to possess weapons.

A. Yes.

Q. What was the rationale for that being an MEL for patients with PTSD?

A. I don't really know. It may have been at the Ottawa level because I remember I had a client that was, like, the

epitome of someone who was safe with weapons, who voluntarily stored his rifles at his brother's place as soon as his first child was born, who was very careful. He trained people in the safe handling of weapons. He trained people on how to use them. He had no history. Like there was no risk factors for this man at all. And he was deeply offended when, at the Ottawa level, when he was to be medically released, that they put that on his MELs. He was deeply offended to the point where his MO and I tried to argue against that but it just seemed to be a thing they did at the time.

Q. Do you think it has something to do with risk?

A. It's possible. It could be risk. It could be, you know, protecting the person from triggering situations. It could be both but I was not privy to why this was done.

Q. All right. Thank you, Dr. Rogers. That's the only question I had.

A. Okay.

EXAMINATION BY THE COURT

(15:39)

THE COURT: Dr. Rogers, I have just a couple of

questions and one of them is going to relate to some acronyms. I have a document that I don't think it's been entered as an exhibit, so I'm just going to refer to the document number. It's CAN052026. It's a document that is entitled "Medical Examination Record". The date on it is 2011-08-24. It's signed by Cpt. M. MacDonald, MD CCFP, and underneath that is written "DGMO". And under "Finalized Recommendations", he has the following. It says: "G5(T6) (and then) specialist follow-up more often than every six months." So the "G5(T6)", can you tell me what that means?

A. Okay. That's part of the TCat terminology where's the G factor - the geographical - and the "5" would indicate that they need specialist follow-up more than every six months. And then the "(T6)" means a time of six months. And so they tend to do it in blocks of three months or six months. And so there's probably an "O" in there as well. "G5(T6)" and then "O"- something.

(15:40)

Q. I was just going to get to that. It's written underneath. It is "O4(T6) (with the words) unfit deployed operational environment."

A. Okay, yeah.

Q. So the "O4" means?

A. The "O4" means you cannot deploy them to a war zone. You probably can't even send them on a training exercise but you have to ask Maj. MacDonald because Cpt. MacDonald is now a military psychiatrist at the base.

Q. And you had indicated, actually, in your evidence earlier, you thought that at one point in time, Cpt. MacDonald had been his medical officer and, in fact, this is the document that would seem to confirm that.

Underneath that ...

A. Yes.

Q. ... there's a second field. It's number 4 under "Remarks" and it apparently is concurred in by Dr. R.B. Russell, M.D., Deputy ... I guess it's Base Surgeon/FS/DMO. And he apparently ... that is dated September 27th, 2011. I think it was the day before Dr. Joshi actually saw Cpl. Desmond.

A. Okay.

Q. So when Dr. Russell signs off on that, what does that signify, if anything, or is that just part of the paperwork?

A. Yeah, it's part of the administrative paperwork. When you change someone to a medical category, the surgeon would look at it and sign off on it unless he had reason to disagree.

Q. All right. I'm just going to see if I can quickly put my hands on a couple of other documents. I have a document and it's entitled "Medical Examination Record" and the date on it is 2013-10-29.

A. Okay.

Q. And the reason for this document, it says "PCat". It is signed ... the examining clinician was Janet Weber. Underneath that, under "Remarks," there's a signature by Maj. L. C. Murphy, Flight Surgeon, and there's another signature at the bottom by an E. Seeger, MD. And then there's the title of "D MED POL/MED," and then I think it's "STDS".

A. Okay, I don't know about the "STDS", but it sounds like ...

Q. Maybe the French acronym.

A. Sounds like ...

Q. Sorry.

A. Yeah, maybe, but it sounds like it would be the document confirming probably a medical release or requesting medical release. And Janet Weber would've been the MO who requested it. It was cosigned by Maj. Murphy who was our base surgeon at the time and she must've been an Air Force member if her title was "Flight Surgeon", but it's the same as, like, the

head doc. at our base at the time. And then "D MED POL", it's Department of Medical Policy.

So if somebody is being medically released, their file and the recommendation from their health records gets sent to Ottawa and there's that small department, D MED POL, and they make the final decision about medical limitations and they either say, Yes, we agree this person needs medical release or they have the power to question it if they wish.

Q. Okay. As part of that same document package that I have here, I have it ... so I'm going to say that that document number is CAN052145_0001. Under the next page, which is _0002, it's a document and it's referred to as a task statement.

A. Okay.

Q. And it goes through infantrymen and ...

A. Yes.

Q. ... there's ... I don't know if you're familiar with it, but it gives a little scenario about general duties and then it says, "MOC-related Duties", and then to the right is "applicable", and then there's a varied number of ranks, I assume, and one is "corporal" and item 13 says: "Remain alert 20 hours a day under combat conditions." And then there's an "x" for "corporal" and it's circled. It seems to me that would

suggest that he lacked that ability to remain alert for 20 hours under combat conditions? Do I read that correctly?

A. That sounds right, yes.

Q. All right. And then on the next page, again with regard to that task, it's item 14 and it says: "Make decisions rapidly and give orders clearly under all conditions." And then that "x" is circled as well, which would suggest to me that Janet Weber had assessed that he could not make decisions rapidly and give orders clearly under all conditions? Do I interpret that correctly?

A. Yes.

Q. The next page, which would be the same document - 52145_004 is a medical examination record dated October 29, 2013. It's again entitled "Generic Task Statement - All CF Members". And then under "Physical Factors", there's ten of them there listed and number 8 is circled. "Must be able to handle and effectively operate a personal weapon." If it's circled, am I correct in assuming that Ms. Weber determined that he was not able to safely and effectively operate a personal weapon?

A. Yeah, and by "personal weapon" they would've meant the military weapons.

Q. I understand that. That would be the weapon that would be issued to him in the course of his military operational duties. Correct?

A. Yes.

Q. So when I read these documents together, that he did not have the ability to remain alert for 20 hours under combat conditions, he could not make decisions rapidly and give orders clearly under all conditions, and that he was not able to handle and effectively operate a personal weapon, those were the conclusions of Ms. Weber on that particular date, October 29, 2013?

A. Yes.

Q. So that being the conclusion of the MO, that's the role she would serve there, and if the purpose of this document was a review, like a PCat review, then are they not effectively confirming that he should not be in possession of, or using, personal weapons that the MEL had limited his ... that employment limitation was perhaps validated by not being able to, for instance, effectively handle and ... sorry, to safely handle and effectively operate a personal weapon?

(15:50)

A. Yeah. And, again, it meant military weapons because

the requirements are really stringent. You have to be able to go without food or sleep for long periods of time and still be able to react quickly to conditions in a war zone.

Q. Right.

A. And so if somebody is ruminating or reacting to certain situations, then yes. So she must've concluded at that time. And that, I believe, was about a month ... that would've been about a month after that time when he was reacting so strongly to the racial comments that he was having trouble functioning, like, he ...

Q. Right. Well, and I think it was Ms. Ward that kind of touched on the issue. So this is how I guess I would look at how the issue of safely possessing and handling firearms in a military context has some carryover to being able to safely handle and utilize firearms in a civilian context if the determination of the MO is that he's not able to safely handle and effectively operate a personal weapon. And let's just look at the word "safely handle" as opposed to "effective operation". And I think effective operation may include actually loading, because there's other documentation that talked about Mr. Desmond having some issues with loading on the range. Leave that aside for a moment, but in terms of safe handling, safe

handling involves lots of things, including how you physically have it in your hands but also judgment? Correct?

A. Yes, because you have to make split-second decisions about whether or not to fire. There's quite strict rules, rules of engagement they call them, which is different from if you're out in the woods hunting a deer, like, admittedly, you have to make a decision there to make sure you've got the target in your sights and that you know it's a deer, for example, but it's not the same ...

Q. And you know what the background is, so that you don't inadvertently cause a round to be flying down range and hit a target you're not pointing ... you're not shooting at.

A. Yes.

Q. Lots of judgments.

A. Yes.

Q. Okay. All right, thank you. So I was just looking for some clarification, particularly as it relates to these MELs and ...

A. And I mean the best person to answer those questions would be Janet Weber because she was the one who wrote it and she would likely remember what went into her decision.

Q. I thank you for the suggestion, Doctor, that's

probably a good idea.

So I think that we're finished with the questions for the day. And Dr. Rogers, I'd like to thank you for your time. I know that you would've spent some time with counsel preparing and reviewing some documentation for today. I can appreciate that having to review some of the circumstances relating to Mr. Desmond, or Cpl. Desmond and his life, may not be all that pleasant for you as well, considering what you said earlier about the circumstances and Cpl. Desmond being the only client that you ever had that wound up in this kind of a situation and the rarity of that event.

So for all of your consideration and preparation in appearing today and giving us your evidence and your insight, it's has been very helpful, I'd like to thank you for your time.

A. Oh, you're welcome.

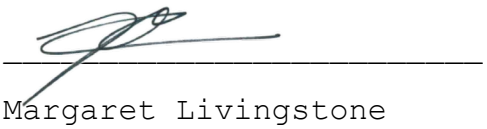
Q. All right, thank you. So we'll adjourn for the day. We'll just close down the record and then we'll just remain here for a few minutes afterwards. Thank you, Dr. Rogers.

WITNESS WITHDREW (15:55 HRS)

COURT CLOSED (15:55 HRS)

CERTIFICATE OF COURT TRANSCRIBER

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



Margaret Livingstone

(Registration No. 2006-16)

Verbatim Inc.

DARTMOUTH, NOVA SCOTIA

March 16, 2021