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 26, 2021

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INDEX

February 26, 2021 **Page**

DR. ANTHONY NJOKU

Direct Examination by Mr. Murray 6

Cross-Examination by Ms. Ward 102

Cross-Examination by Mr. Macdonald 105

Cross-Examination by Ms. Miller 108

Cross-Examination by Mr. Rodgers 129

Re-Direct Examination by Mr. Murray 146

Examination by the Court 147

EXHIBIT LIST

Exhibit	Description	Page
P-000245	*Curriculum Vitae* - Dr. Anthony Njoku	6

1 **February 26, 2010**

2 **COURT OPENED (09:31 hrs.)**

3

4 **THE COURT**: Thank you. Good morning.

5 **COUNSEL:** Good morning, Your Honour.

6 **THE COURT**: Good morning, Dr. Njoku. Good morning, Mr.

7 Browne.

8 **MR. BROWNE:** Good morning, Your Honour.

9 **DR. NJOKU:** Good morning, Your Honour.

10 **THE COURT**: Mr. Brown, I understand the nature of your

11 request. I have no difficulty with that.

12 **MR. BROWNE:** Yes. Thank you, Your Honour. I just didn't

13 want to cause any distraction to counsel and to the Inquiry and

14 I thought that would be the best approach. Unless there is

15 something arises then I will turn on my camera and my

16 microphone. Thank you.

17 **THE COURT**: That will be fine, great. Thank you.

18 Perhaps then we could have the doctor sworn, please.

19

20

21

22

1 **DR. ANTHONY NJOKU affirmed, testified:**
2 **THE COURT**: Mr. Murray?
3
4 **DIRECT EXAMINATION**
5
6 **MR. MURRAY:** Thank you, Your Honour. Good morning, Dr.
7 Njoku. How are you this morning?
8 **A.** I'm fine. Good morning, Counsel.
9 **Q.** Are you able to hear me okay, Doctor?
10 **A.** Yes, I can.
11 **Q.** Okay. If along the way you have any difficulty
12 hearing me or it's unclear for any reason, just shout and we'll
13 see if we can make it clearer.
14 **A.** Yes, sir.
15 **Q.** Okay. Dr. Njoku, can you tell the Court or the
16 Inquiry, I should say, your full name?
17 **A.** My name is Anthony Njoku. Njoku is my surname.
18 **Q.** And to ensure that I'm pronouncing it correctly, it's
19 en-JO-ku. Is that correct?
20 **A.** Yes, it is.
21 **EXHIBIT P-000245 - *CURRICULUM VITAE* - DR. ANTHONY NJOKU**
22 **Q.** Dr. Njoku, you provided us your *curriculum vitae* and

1 it's been marked as an exhibit, I believe Exhibit 245. Do you
2 have a copy of your *CV* there with you?
3 **A.** Yes, I do.
4 **Q.** I just wanted to ask you a few questions about it and
5 about the nature of your qualifications.
6 Doctor, you are a psychiatrist are you?
7 **A.** Yes, I am, sir.
8 **Q.** I wonder if you could tell us just about your
9 training, where you received your medical degree, and where you
10 trained as a psychiatrist.
11 **A.** So my primary medical degree was in Nigeria at the
12 University of Ibadan Medical School - Medical College. I
13 graduated as a medical doctor with an MBBs, Bachelor of Medicine
14 and Bachelor of Surgery, in 1987. Worked in Nigeria from them
15 up 'til I left to move to the UK.
16 So I went to the UK in 1999 and thereafter I ... after
17 going through my initial practice exams to allow me practice in
18 the UK, I then started a residency training program in
19 psychiatry. So I was in psychiatry training up until 2005, by
20 which time I had completed my specialist training as a
21 psychiatrist with an MRC Psych, which is the Royal College of
22 Psychiatry in the UK.

1 Following that, I worked initially in a forensic setting in
2 the UK, then started a specialty interest training in a trauma
3 clinic in London, the London Trauma Clinic, and it was after
4 that that I moved to Canada to my current job in 2010. I've
5 been here since 2010.
6 **Q.** All right. Thank you, Doctor. And in your personal
7 statement on your *curriculum vitae* you say: "I have an interest
8 in the development of PTSD among high-risk populations such as
9 refugees, and in the etiology and prevalence of complex PTSD
10 within forensic populations. I'm also interested in exploring
11 risk and predictive factors of PTSD."
12 When did you first begin to develop your interest in
13 treating patients with trauma?
14 **A.** My interest began in 2005 when I joined the London
15 Trauma Clinic on a specialty interest program. The London
16 Trauma Clinic was actually part of a specialist NHS service. In
17 the UK we don't have specialist trauma clinics as, say, the OSI
18 here, so that was something quite early on that they had
19 established but at the time it was primarily geared towards
20 working with the large refugee population.
21 So my interest and my experience in the UK was primarily
22 with refugee populations, whereas since I came to Canada it's

1 been more with first responders, veterans and RCMP officers.
2 **Q.** And I see in your *CV*, I think it's on page 7 you say:
3 "I work one day per week in an honorary capacity at the
4 Traumatic Stress Clinic, London, England, offering assessments
5 and treatments of PTSD patients, including the use of EMDR and
6 trauma-focussed CBT, or cognitive behavioural therapy."
7 And that you say was in 2005?
8 **A.** From then, yes.
9 **Q.** And, Doctor, at that time the patients you were seeing
10 you said were primarily in the refugee population?
11 **A.** Yes, sir.
12 **Q.** The nature of the trauma, I guess, that you would see
13 amongst patients in the refugee population in 2005, can you give
14 us a sense of what you were seeing and what they had
15 experienced?
16 **A.** So most of them would have been coming from war
17 trauma. Most of them would have been fleeing from trauma.
18 Besides that, however, in terms of the symptom presentations, it
19 would essentially be the same as with the veteran population
20 here. But the major difference would have been around the kind
21 of trauma experience that they would have been exposed to.
22 **Q.** I see. But at the end of the day, the symptomotology

1 that you see is similar to the military population?

2 **A.** Quite very similar, sir, yes.

3 **Q.** Okay. And at that time you became familiar, or maybe
4 you already were, with the use of trauma-focussed cognitive
5 behavioural therapy and the EMDR. Were those both treatment
6 modalities that you used or saw being used?

7 **A.** Yes. Well, if I may qualify it? So primarily as a
8 psychiatrist my role is actually more to do with prescribing
9 medication. So assessment, diagnosis, but essentially treatment
10 by way of medications ...

11 **Q.** Yes.

12 **A.** ... and pharmacotherapy.

13 Having said that, because of the particular interest I had,
14 I joined a clinic, it was essentially more a psychologically-run
15 clinic, so that afforded me the opportunity to actually learn
16 the psychotherapeutic skills I needed, especially
17 psychotherapeutic skills I needed, while I, in turn, offered
18 them more of a psychiatric service. So it became almost a *quid*
19 *pro quo* I think. It became almost a *quid pro quo* arrangement.
20 So I offer my psychiatric services, in turn I was given quite
21 good training in terms of especially psychotherapy for PTSD.

22 **Q.** I see. Okay. And, again, in your personal statement

1 you make reference to becoming interested in particular in the
2 etiology and prevalence of complex PTSD. That's a term that
3 we've heard before. Do you distinguish or is there a way to
4 distinguish, I guess, a post-traumatic stress disorder that is
5 complex or not?
6 **A.** In fairness, it doesn't exactly refer to PTSD. So
7 complex PTSD is a concept that hasn't even gained full approval
8 in terms of a specific diagnostic category but what is actually
9 used to describe more of a personality disorder types that arise
10 from repetitive long-standing trauma, particularly from primary
11 caregivers. So it's actually more to describe personality
12 disorders.
13 **(09:40)**
14 **Q.** Okay. So a patient who may be suffering from post-
15 traumatic stress disorder who also develops or has a personality
16 disorder, that would be the situation where you might use that
17 term?
18 **A.** No, I would simply use the term with regards to a
19 patient who has complex presentations that would have
20 transcended right across their adulthood, and usually could be
21 related to repetitive ... you could say repetitive traumatic
22 experiences from childhood.

1 **Q.** Understood. And I assume that patients with post-
2 traumatic stress disorder often have a complex presentation in
3 that they have a number of things going on?
4 **A.** Yes, true.
5 **Q.** And you said you were also interested in exploring
6 both risk and predictive factors for post-traumatic stress
7 disorder.
8 Are there particular ... in your work, particular risk and
9 predictive factors for post-traumatic stress disorder that
10 you've come to see in your work?
11 **A.** There are several risk factors. We ... in a sense,
12 it's almost the Holy Grail to be able to, you know, identify
13 predictive factors, so we haven't quite ... there isn't as much
14 evidence as for particular predictive factors, but certainly
15 there are associated risks.
16 So if something like veterans who have been exposed to war
17 trauma, that is a significant risk. There's higher risk amongst
18 men. There's risk amongst particular subsections of the
19 population as well. And, of course, people who have had
20 premorbid psychiatric conditions would also be exposed to some
21 risk.
22 **Q.** Understood. And you say ... Is there a significant

1 amount of literature on risk and predictive factors or is that
2 an area that still requires more study?
3 **A.** There's significant evidence on risk. There's less so
4 in terms of predictive factors.
5 **Q.** Okay.
6 **A.** So, for instance, in the military, it would be of
7 immense help or immense benefit if you could *ab initio* predict
8 who would significantly be at risk of PTSD and hence not deploy
9 them but we haven't got that as of now.
10 **Q.** I see. Okay. Obviously that would be helpful if we
11 could, in a sense, detect who might be the most vulnerable to
12 developing PTSD?
13 **A.** Yes.
14 **Q.** All right. So you came to work in the Operational
15 Stress Injury clinic in January of 2010. And was that as a
16 result of the interest that you had developed in treating PTSD
17 and other forms of trauma?
18 **A.** Yes, it was. And when I was being interviewed, it was
19 offered as a particular reason why they wanted me to move to
20 Canada to that position.
21 **Q.** Okay. And just so I understand. Your area of ... you
22 are a general adult psychiatrist, I guess. Is that the correct

1 way to describe it?
2 **A.** It would be, yes, sir.
3 **Q.** Okay. And so you have an interest in and obviously
4 you've treated patients with post-traumatic stress disorder.
5 That isn't a formal specialty or sub-specialty in psychiatry I
6 take it, but it is an area wherein you have an interest and now
7 a wealth of experience. Is that correct?
8 **A.** Yes, sir.
9 **Q.** All right. So can you tell us a little bit about your
10 work at the OSI clinic in New Brunswick? And we've heard some
11 evidence, obviously, about the clinic, but I'm going to ask you
12 the nature of the population that you see at the OSI clinic.
13 Who is your patient base at the OSI clinic?
14 **A.** So at the OSI clinic we would normally see active RCMP
15 members as well as retired RCMP members, then we see veterans.
16 Initially, we used to sort of bridge and see some active DND
17 patients but currently we're only seeing veterans - see Canadian
18 Force members. So that will be veterans, CF members, active or
19 veteran RCMP officers.
20 **Q.** Okay. And the breakdown soldier versus RCMP officer,
21 I understand it's more from the military side, is it?
22 **A.** Yes, it is.

DR. ANTHONY NJOKU, **Direct Examination**

1 **Q.** All right. So the patients that you see, obviously
2 it's a stress injury or operational stress injury clinic, I
3 would take it then that the majority of the patients that you
4 see have some form of post-traumatic stress disorder along with
5 other conditions. Is that correct?
6 **A.** That would be correct, sir, yes.
7 **Q.** Apart from PTSD what other conditions do you see in
8 the patients that you treat at the OSI clinic?
9 **A.** We would see people presenting with major depression.
10 We see people presenting with substance use disorders. Some of
11 them will be presenting with personality disorders as well.
12 Sometimes we've had people present with psychosis. Sometimes as
13 comorbid to their PTSD. Sometimes as just primary disorders or
14 primary conditions in themselves.
15 We've had some people with bipolar present and
16 schizophrenia very rarely. So the people who would get referred
17 to us would be, like the term terminology says, operational
18 stress injury, which is an umbrella term, but underlying that it
19 relates to trauma that is related to their service. So mental
20 conditions related to their service. And sometimes they would
21 want to differentiate between schizophrenia or bipolar as not
22 being primarily related to their service.

1 **Q.** Okay. And the referral process for the OSI clinic,
2 where do your referrals come from or what is the process for a
3 patient being referred to the OSI clinic in New Brunswick?
4 **A.** All referrals to the OSI clinic would have to come
5 from VAC, Veterans Affairs Canada. So that's our primary
6 referral. We wouldn't otherwise take in referrals from any
7 other sources.
8 **Q.** And that's for soldiers obviously, not for the RCMP?
9 **A.** Yeah, that's correct. Yes.
10 **Q.** All right. And from, I guess, a medical point of
11 view, I understand the referral comes through VAC. Will there
12 typically be a treating physician who recommends that a person
13 attend the OSI clinic? How does that work?
14 **A.** No. No, not necessarily, it could simply be that VAC
15 has assessed somebody and they could probably want the person
16 assessed for a disability.
17 So when patients are referred, they could either have a
18 primary condition already diagnosed previously, or some of them
19 would not have any diagnosed condition and are being referred to
20 us for, say, an assessment for disability.
21 So part of our function would be to either assess people
22 for disabilities, in which case that goes back to VAC and that

1 sets up a whole process of awards, pension awards and all that,
2 disability pension awards, or people are being referred to us
3 for treatment.
4 Sometimes people could be referred to us for a second
5 opinion, in which case they'd already been seen by some other
6 clinician and then they are requesting a review or a re-
7 assessment for a second opinion. So not everybody would
8 necessarily be assigned or be working with a clinician or a
9 doctor or a psychiatrist.
10 **Q.** Right. So can you give us a sense of how many of the
11 people that are referred to the OSI clinic are coming in for a
12 disability assessment and how many may have already have a
13 diagnosis and be coming in for treatment?
14 **A.** I probably won't give it justice but disability
15 assessments would be something like less than 10 percent.
16 **Q.** I see. So the majority of people that come to you
17 then do have a diagnosis and are, I guess I'd say in the
18 treatment stream. Is that a way of putting it?
19 **A.** They would have had a diagnosis and they would be
20 referred to us for treatment, yes.
21 **Q.** Is there a triage process when somebody is initially
22 referred to the OSI clinic?

1 **A.** Yes, sir, we do triage patients. Yes.
2 **Q.** And how does that work?
3 **(09:50)**
4 **A.** So when we get a referral, it would initial- ... the
5 triage comes at the intake. It starts at the intake, which is
6 managed by the nursing team. So the nurses will contact the
7 patient, they will run through a set of questionnaires, and then
8 at that point they sort of triage the urgency or otherwise. And
9 also they will probably at that point be able to determine the
10 streaming: whether this is a disability assessment, whether
11 this is somebody who needs to come for treatment and which case
12 is it, primarily psychiatric or is it more the psychotherapy.
13 And then that's brought forward to the multi-
14 interdisciplinary team meeting where there's further discussion
15 around that and then before the patient is assigned to whoever
16 is going to pick him up. So that would be the process.
17 In between, the nursing team who would have done the
18 initial intake remain in contact and so that would also be the
19 primary or initial contact for the patient. They may start some
20 psycho-education. They may even give advice to the community
21 physician on how to also support the patient until they are
22 formally seen by us.

1 **Q.** Okay. So when the nurse does the triage, then
2 there's, I take it, a standard set of questions or areas that
3 that nurse would need to cover to determine how to triage the
4 patient?
5 **A.** Yes, sir.
6 **Q.** The triage nurse you said also will actually do some
7 psycho-educational work initially before the person even gets or
8 before the case gets to the interdisciplinary team?
9 **A.** Yes, sir.
10 **Q.** What would that psycho-education look like?
11 **A.** Initially, it's more ... a lot of it will be
12 supportive; maybe getting them to understand the nature of their
13 illness, at least beginning that process. There might be
14 initial basic tools we could share with them. There might be
15 information leaflets that we share with them. There certainly
16 would be benefitting sharing contacts of resources, so usually
17 we'll put them in touch with appropriate resources that would
18 help support them.
19 Then all of that while the nurses staying in contact with
20 them is usually ... Probably one of the best things about it is
21 just having that point at which you can call on if you do need
22 any help extra.

1 **Q.** Okay. All right. So that triage nurse then is
2 available to the patient until they get set up with another
3 therapist to help them out or point them toward resources and so
4 forth?
5 **A.** Yes, sir. Yes.
6 **Q.** All right. So the ... When a person is referred and
7 they initially are in contact with the triage nurse, typically
8 what materials will come with that patient or what would be
9 accessible by the triage nurse in making that initial
10 assessment?
11 **A.** So it would be the referral request, the referral
12 note. Often ... In fact, that is also sometimes part of what a
13 triage nurse would have to do. So sometimes the triage nurse
14 will have to check up and sort of track down previous notes,
15 clinical notes, and all that. They don't always come in the
16 pack, in the referral pack, at the initial stage.
17 So once the ... all of those notes are together, the triage
18 nurse has access to all of the previous clinical records as well
19 as the referral history or referral request.
20 **Q.** So if a patient, for example, is coming from the
21 Canadian Armed Forces, being discharged, and was treated by
22 physicians in the Canadian Armed Forces, do you have a sense if

1 those records typically would be with the patient or is it
2 something that the triage nurse typically has to chase down?
3 **A.** They should come with the referral.
4 **Q.** Right.
5 **A.** Sometimes they require chasing down.
6 **Q.** Okay, fair enough. So the triage nurse makes an
7 assessment whether this person may need psychiatric help or
8 psychotherapy or a combination of both. And I take it then does
9 a ... puts that in writing for the interdisciplinary team or
10 does that person attend the meeting? How does that work?
11 **A.** The triage nurse will attend the meeting and do a
12 presentation.
13 **Q.** Okay. And at some point, the interdisciplinary teams
14 meets and makes a decision about the course of treatment, do
15 they?
16 **A.** Yes, right there. During that presentation it will be
17 discussed, the urgency, if there are risks, you know, whatever
18 special factors are associated with that particular referral.
19 Then at the end of it, we'll probably decide is this very
20 urgent, is this mildly urgent, is this, you know ... does this
21 go to psychiatry, does this go to psychotherapist? Is it
22 somebody who wants a male? Is it someone who prefers French

1 speaking? You know, all of that gets sorted out right there
2 with all the members of the team together.
3 **Q.** So the interdisciplinary team itself, who sits on that
4 team or who is part of that team?
5 **A.** All of the clinical staff at the OSI clinic ...
6 **Q.** Okay. So let me ask you then ...
7 **A.** ... so it would include a different ... it would
8 include ...
9 **Q.** Who is the clinical staff?
10 **A.** ... a different psychiatrist. It would include a
11 different psychiatrists, the psychologists, the social workers
12 and with other clinical staff we have. And then of course we
13 have somebody who keeps records, administrative stuff, to keep
14 records of the meeting.
15 **Q.** How many psychiatrists are currently at the OSI clinic
16 in New Brunswick?
17 **A.** Currently we have three.
18 **Q.** Three.
19 **A.** Three psychiatrists now.
20 **Q.** Do the psychiatrists that you have there now, do they
21 have any areas of specialization or are the three of you
22 basically ... I guess, do you all have the same areas of

1 specialty, I guess, if I could put it that way.
2 **A.** Yeah, same areas of speciality I would say. Yes, sir.
3 **Q.** All right. And then you said you have psychologists
4 as well?
5 **A.** Yes. We have three psychologists.
6 **Q.** Okay. And you said social workers ...
7 **A.** Three psychologists and three social workers.
8 **Q.** Okay. So three psychiatrists, three psychologists,
9 three social workers?
10 **A.** That's correct.
11 **Q.** And then there ...
12 **A.** It fluctuates. It fluctuates, though, so it's not ...
13 there's always a need to either recruit more people or people
14 are leaving or people are shifting jobs so ...
15 **Q.** Right.
16 **A.** ... it's not a constant thing.
17 **Q.** Does your patient load fluctuate a bit? In other
18 words, does it go up and down or do you try to keep at a set
19 amount of people that you're treating at a given time?
20 **A.** We treat as many people as we get, so we don't set the
21 patient load in terms of treatment. What tends to fluctuate is
22 the referrals into the service. So the referrals into the

1 service, those fluctuate up and down depending on whatever
2 circumstances are out there.
3 **Q.** Okay. So ... and you also have then mental health
4 nurses as well or registered nurses, do you, to ...
5 **A.** Yes, right now we have two registered psychiatric
6 nurses.
7 **Q.** Psychiatric nurses, okay. And do they perform the
8 triage? Is it their responsibility or is it ...
9 **A.** They're the ones who ... yes, sir, they are the ones
10 who do the triage.
11 **Q.** Okay. All right. So the interdisciplinary team meets
12 about the referrals. How often does that team meet?
13 **A.** Every week. Every Thursday.
14 **Q.** Thursday, okay. And at those meetings, then, you make
15 the decisions about referrals, about how those people are going
16 to be treated and what's going to happen with them. Is that
17 correct?
18 **A.** Yes, sir.
19 **Q.** All right. So you had obviously experience in
20 treating Lionel Desmond, the person about whom we're speaking
21 here today. Do you recall treating Lionel Desmond?
22 **A.** Yes, sir, I do.

1 **Q.** There's a bundle of documents I guess that have been
2 marked as an exhibit here, they're Exhibit 244, and they're the
3 records from the OSI clinic in New Brunswick. Do you have those
4 close at hand?
5 **A.** Yes, sir, I do.
6 **Q.** Okay. So we've numbered them, we've given them page
7 numbers, and on page 81 of the record there's a note which I
8 believe relates to the triage of Lionel Desmond from May 7th,
9 2015. It may be on the screen there as well.
10 **(10:00)**
11 **A.** Yes, sir.
12 **Q.** So am I correct? Is that the entry in the file
13 relating to the triage of Lionel Desmond?
14 **A.** Yes, it is.
15 **Q.** And that was done by a Christine Lillington, RN?
16 **A.** Yes, sir.
17 **Q.** Okay. So am I correct then that Lionel Desmond's
18 formal triage process was done, it would appear, by telephone by
19 Nurse Lillington on May 7th, 2015?
20 **A.** Yes, sir.
21 **Q.** Is this triage note, is that typical of what you would
22 see after a triage nurse meets with a prospective patient?

1 **A.** Yes, sir.

2 **Q.** Is triage typically done by telephone?

3 **A.** Yes, sir. There's a telephone triage as well as an
4 in-person meeting. So the telephone triage is the first
5 contact, yes.

6 **Q.** I see. And then would the same nurse ... well, let me
7 ask you, prior to COVID, would the same nurse then meet in
8 person with the patient?

9 **A.** Yes, sir, typically.

10 **Q.** Okay. And how long would those two meetings be - a
11 telephone triage and then an in-person triage meeting?

12 **A.** Not normally longer than, say, two weeks, I don't
13 think. It's usually pretty soon after.

14 **Q.** Okay. So two weeks between the telephone triage and
15 the in-person triage?

16 **A.** On average, yes, I would say.

17 **Q.** Do you still meet with people in person now? Are you
18 doing it by video or something?

19 **A.** At the moment, it's a mix.

20 **Q.** Okay.

21 **A.** Some people in person. Much fewer people in person,
22 actually.

1 **Q.** Right.
2 **A.** Telephone and video.
3 **Q.** Okay. And the length of time that the nurse doing the
4 triage would typically meet with someone, do you have a sense of
5 that? Is it an hour meeting or a half an hour? Or it just
6 depends, I suppose.
7 **A.** No, I don't. The in-person could be anything up to
8 two hours sometimes, so again, it would depend on the
9 presentation of the person, it would depend on how much ... how
10 complex they might be presenting, how acutely unwell they might
11 be at the time.
12 **Q.** All right. So many factors, obviously, would come
13 into play in making that determination how long is needed to
14 triage?
15 **A.** Not how long is needed but how long the triage might
16 end up being.
17 **Q.** Right, okay.
18 **A.** Yes.
19 **Q.** So in Lionel Desmond's case, it would appear that the
20 next entry, which is just on page ... I think I had said ... may
21 have gotten the pages wrong, but on page 80, there's an entry
22 from Mathieu Murgatroyd from June 24th, 2015, which says,

1 "Therapy session number one."
2 **A.** Yes, sir. Page 80, yeah.
3 **Q.** So in Lionel Desmond's case, after he saw the triage
4 nurse either once or twice, I assume the interdisciplinary team
5 would've met between that time and June 24th when he started to
6 see Dr. Murgatroyd for psychotherapy. Is that correct?
7 **A.** Yes, sir.
8 **Q.** Do you recall the interdisciplinary team meeting
9 regarding Lionel Desmond?
10 **A.** Honestly, I don't recall specifically, no.
11 **Q.** Sure. It was also determined that he would need
12 psychiatry, I assume, because you ultimately did see him and I
13 believe you ...
14 **A.** Yes.
15 **Q.** ... first saw him, or the first entry, it would
16 appear, is on page 33 of the exhibit, and that relates to an
17 assessment you did on August 31st, 2015?
18 **A.** Yes, sir, that's correct.
19 **Q.** So I'd like to ask you some questions about that
20 meeting on August 31st, 2015, and what you saw. The document
21 that we have on pages 33, 34, and 35, I guess, that's the
22 assessment report, is it, that came about as a result of your

1 meeting with him on August 31st, 2015?

2 **A.** Yes. Yes, it was, sir.

3 **Q.** Okay. Is that a document you would've created close

4 in time to the meeting with Lionel Desmond?

5 **A.** Yes, indeed, sir.

6 **Q.** Okay. So can you give us a sense, when you met with

7 him on August 31st, 2015, you would've had the triage note from

8 Nurse Lillington. Would you have had other materials from the

9 Canadian Armed Forces?

10 **A.** I would have had access to Dr. Joshi's notes, yes.

11 **Q.** And Dr. Joshi ... we've heard from Dr. Joshi. He was

12 the psychiatrist that treated Lionel Desmond in the Canadian

13 Armed Forces?

14 **A.** Yes, sir.

15 **Q.** Would you have had access to other parts of his

16 medical records, say, his record of his treating psychologist in

17 the Canadian Armed Forces?

18 **A.** The treating, I would have, but going through the

19 notes, the treating psychologist notes, well, I think we had

20 just very few.

21 **Q.** If a patient such as Lionel Desmond was treated in the

22 Canadian Armed Forces by both a psychiatrist and a psychologist,

1 would you typically get the notes of both of those
2 professionals?
3 **A.** With a psychologist, it's a little bit different. We
4 typically will get the notes for the psychiatrist for sure.
5 With a psychologist, sometimes the notes will come mostly as a
6 summary, so this is the kind of treatment or this is his
7 response, closed or not closed. So we wouldn't typically get
8 regular progress or updates as per each visit.
9 **Q.** I see, okay. And if a patient is being treated by a
10 psychologist at the OSI clinic along with yourself, would that
11 psychologist be able to access ... and I appreciate you're not
12 the psychologist, but would that person typically be able to
13 access other more detailed records from a CAF psychologist if
14 they wanted to?
15 **A.** Usually, they will probably want to communicate with
16 them directly. They will probably want to talk to them and find
17 out what form of treatment, what challenges. And this is
18 particularly mostly where they have to identify some specific
19 concerns, you know, share about what treatment they had or
20 you're concerned about their treatment compliance, you know,
21 that sort of thing. Then you will be asking or you will be
22 reaching out to them specifically.

1 **Q.** And have a conversation with them.
2 **A.** Yes, sir.
3 **Q.** Okay. If there were other medical records from the
4 CAF, you know, if a person had physical injuries, that type of
5 thing, that were treated, would those be available to you
6 normally or does it depend, I guess?
7 **A.** It would depend, but if we asked, we could get them,
8 yes.
9 **Q.** And that process of asking, we've heard about a
10 database, the CFHIS. I believe I have the acronym right. Do
11 you have access to that system?
12 **A.** Not directly. It would have to be through VAC. So
13 sometimes it gets ... if they are still ... so I think there's a
14 period of time it takes before the records get transferred up to
15 Ottawa. Then they get archived and then it's a little bit more
16 difficult to get access, but if they are still with DND, DND
17 records is a lot easier and smoother to get access to them.
18 **Q.** Does your staff at the OSI clinic - you'd mentioned
19 the triage nurse doing some of this work - would they, if you
20 needed those records, would they take the steps necessary to
21 obtain them?
22 **A.** Yes, but again, it would be through VAC not us

1 directly requesting, yeah.

2 **Q.** Okay. If a soldier who left the CAF and was referred
3 to you by VAC, in your experience would they sometimes ask for
4 their whole medical record before they leave the Canadian Armed
5 Forces, in a file or on a disk, and bring that to you. Does
6 that ever happen or is that not something that happens?
7 **(10:10)**
8 **A.** It's happened. It's happened a few times, yes, sir.
9 **Q.** Okay. I take it then not all of the time?
10 **A.** No, not most of the time actually.
11 **Q.** Okay, all right. So you had access then to the triage
12 note, to Dr. Joshi's notes from the Canadian Armed Forces when
13 you met with Lionel Desmond. Would you have had occasion to
14 review those prior to seeing him perhaps as part of the IDT
15 meeting?
16 **A.** Yes, I would have had a chance to look over them.
17 **Q.** Okay. And the initial assessment of a patient such as
18 Lionel Desmond, how long would you typically plan to meet with
19 him on the first occasion, first meeting? How long would that
20 be?
21 **A.** It would normally be anything between two or three
22 hours.

1 **Q.** Two to three hours, you say?
2 **A.** Yes, sir.
3 **Q.** All right. So a fairly comprehensive assessment first
4 time out.
5 **A.** Indeed, that would be my opening line. That is the
6 first meeting, so I would have to go over every detail,
7 irrespective of what's being said or known before.
8 **Q.** So if a person comes to you having had a diagnosis
9 such as post-traumatic stress disorder, I assume you have to
10 confirm that yourself and feel comfortable with that diagnosis?
11 **A.** Yes, sir.
12 **Q.** What form would this first meeting take? In other
13 words, would it be conversational or what would happen?
14 **A.** It's mostly conversational. So it would start with an
15 introduction, my introduction of myself, perhaps talk about his
16 expectations, then set the stage of what the interview process
17 would look like. And then when I get started, it would start
18 usually with more open-ended questions, and it's only much later
19 I would probably go down to the direct questioning. So the idea
20 would be to facilitate a more free-flowing, conversational
21 assessment rather than a prescriptive or directive process.
22 **Q.** Okay. So at the outset of the meeting, you would kind

1 of let the patient tell you some of the things that they may
2 want to tell you first?
3 **A.** Absolutely so. Yes, sir.
4 **Q.** Okay. You would want to, I assume, obtain some kind
5 of a medical history from the patient from their perspective?
6 **A.** Yes, indeed, sir.
7 **Q.** Would you want to obtain, in the case of a military
8 veteran, a bit of a history of what they saw in combat or in the
9 military?
10 **A.** Yes, I would. That would be part of it.
11 **Q.** And do you also obtain, or I assume you obtain,
12 personal information, family, that type of thing?
13 **A.** Yes, sir.
14 **Q.** Do you have a recollection of what your impression of
15 Lionel Desmond was when you first met him at this meeting?
16 **A.** If I may go through the notes because I think, in
17 looking over the notes it kind of captured what the essence of
18 my impression was essentially then.
19 **Q.** Yes.
20 **A.** And it's probably not any different now.
21 **Q.** Sure.
22 **A.** So my impression at the time was of a very distressed,

1 agitated young man who clearly, I felt at the time, was
2 exhibiting significant severe symptoms of PTSD.
3 **Q.** Okay. And obviously, at that time, you would've seen
4 a large number of patients with PTSD from a military background.
5 Correct?
6 **A.** Yes, sir.
7 **Q.** Can you give us a sense of how Lionel Desmond's
8 presentation compared to other people you saw with PTSD in terms
9 of the severity of his condition and his symptoms?
10 **A.** In terms of severity, I would have rated him quite
11 severe. Closer to the upper end of it, of severity scale.
12 **Q.** And what symptoms or what were you seeing in him that
13 caused you to say that he would be at the high end of the scale?
14 **A.** So it would mostly be in terms of his level of
15 agitation, in terms of his preoccupation, how much reliving
16 symptoms he was struggling with, how much dysfunction it was
17 causing him, how much treatment he had indeed had up to that
18 point and yet was presenting this way, and how much insight he
19 had as well.
20 **Q.** The issue of insight. In your experience, do some
21 soldiers have, or perhaps more generally patients with PTSD,
22 have difficulty understanding their condition or understanding

1 the degree of the seriousness of their condition?
2 **A.** Most PTSD patients would ... could have difficulty
3 understanding their condition, so that wouldn't count in terms
4 of my assessing their insight. That's just not, you know, not
5 understanding. The issue really is their understanding of the
6 severity.
7 **Q.** I see.
8 **A.** Or their appreciation of how much is impacting them or
9 how much is influencing their struggles.
10 **Q.** And did Lionel Desmond seem to have an understanding
11 of how much his condition was impacting him or how serious it
12 was?
13 **A.** I believe I rated his insight as moderate. So just
14 looking at page 34, I'd said his insight was only moderate. I
15 didn't think he completely appreciated the severity and I didn't
16 think he completely appreciated the requirement for more
17 consistent treatment although he said he'd been compliant. So,
18 sir, I think that's what I was trying to capture there.
19 **Q.** Right, okay. And obviously, if a patient lacks
20 insight into their condition or the severity of it, that may
21 impact on the success of treatment, I assume, would it?
22 **A.** Yes, sir.

1 **Q.** So at the point that you saw Lionel Desmond, he had
2 already started seeing your psychologist, Mathieu Murgatroyd,
3 and you were now seeing him for psychiatric care. Did you have
4 a sense of what would be needed going forward at that initial
5 meeting?
6 **A.** I believe so, yes, sir.
7 **Q.** And we'll talk about his treatment plan in a moment,
8 but I guess just more generally, was he somebody that you
9 thought was going to need a lot of help?
10 **A.** So yes, I thought he presented in a very complex way.
11 I thought he would need quite a lot of help. I thought he would
12 ... I'm going to say a lot of help, but I would have to put in a
13 lot more effort in even managing and building that level of
14 insight in getting him to be more compliant with treatment in
15 engaging him with the process. So those are quite significant
16 challenges I anticipated, yes.
17 **Q.** You said he was agitated and distractible and you said
18 it was difficult to get a coherent linear account of things from
19 him. Can you just give us a sense of what that was? He had
20 difficulty staying on track when he was talking to you or
21 remembering things in a linear fashion? What were you seeing
22 there?

1 **A.** So what I was seeing was a lot of destractibility, but
2 in terms of being preoccupied with his internal stuff. So he
3 got very preoccupied with the trauma record, trauma recounts,
4 even when we weren't talking about it. He kept coming back to
5 that again and again and that was, I thought, primarily another
6 sort of measure of how severely reliving he was in terms of that
7 assessment, during that assessment. So I found him to be
8 reliving symptoms, reliving memories, to the extent it was
9 actually interfering in his ability to stay concentrated on what
10 we were discussing.
11 **Q.** And the trauma that he was reliving, do you recall
12 what he was primarily focussed on when you were meeting with him
13 in August of 2015?
14 **A.** It was about his trauma experience from the war.
15 **Q.** From combat?
16 **A.** From combat, yes, sir.
17 **Q.** Okay. So he came to you with a diagnosis of post-
18 traumatic stress disorder and major depressive disorder. So you
19 would've had those diagnoses, I guess, that were made by Dr.
20 Joshi or others prior to that when you met with him first?
21 **A.** Yes, sir.
22 **Q.** And he was on a drug regimen when he came to you, and

1 you say in your letter, prior to his release, he was seen at
2 Base Gagetown and was on Effexor XR, risperidone, zopiclone, and
3 Ativan. And we've heard about those drugs, obviously, in the
4 past, but you can give us your thoughts on them as well and just
5 tell us what is Effexor XR and what is it prescribed for?
6 **(10:20)**
7 **A.** Effexor is an antidepressant, so it's prescribed for
8 depression. Risperidone is an antipsychotic, but it's also
9 prescribed for anxiety. Sometimes we'll prescribe it as a
10 sedative or tranquilizer if somebody is getting too agitated or
11 overly angry or overly aroused. So that's what we'd use the
12 risperidone for as well. And zopiclone is a hypnotic agent
13 which is to help with sleep.
14 **Q.** Yes.
15 **A.** Ativan was to help with ... it's an anxiolytic to help
16 with relaxation and managing his anxiety, basically.
17 **Q.** And risperidone is the drug that helps with
18 nightmares, does it?
19 **A.** Not so much, no. Actually, no.
20 **Q.** Okay. QHS ...
21 **A.** Risperidone would be mostly for ... sorry?
22 **Q.** No, go ahead.

1 **A.** QHS at night because it has sedative properties.
2 **Q.** I see. Those drugs, the four drugs that he was taking
3 at the time, did they seem to ... I guess, in your experience,
4 would those have been typical drugs and typical doses for a
5 patient with post-traumatic stress disorder and major depressive
6 disorder?
7 **A.** Unfortunately, there are no typical drugs or typical
8 doses. That's one of the challenges we've always had. As a
9 matter of fact, when it comes to pharmacotherapy,
10 pharmacotherapy is not necessarily the mainstay of treatment for
11 PTSD. Pharmacotherapy is exactly applicable in these situations
12 where people are overly agitated and perhaps would not be able
13 to engage consistently with psychotherapy talk treatment.
14 That's where we come in. But unlike depression, we don't have,
15 like, just one medication for PTSD. So essentially, we end up
16 trying to manage it kind of symptomatically. So we go for the
17 symptomatic treatment. So, like, his agitation, there are
18 several other antipsychotic agents that can be used, again
19 depending on his profile and depending on his tolerability.
20 Equally, his sleep. There are many other hypnotic agents we
21 could use. And then on and on and on.
22 **Q.** Okay. So if I understand you, the primary treatment

1 for PTSD is the psychotherapy, and the pharmaceutical treatment
2 treats the symptoms to allow the psychotherapy to work.
3 **A.** Absolutely, sir. Yes, sir.
4 **Q.** Okay. I guess then, obviously, you were just learning
5 about him on this day but did that drug regimen surprise you in
6 any way or was that ...
7 **A.** No, sir, no. No surprises, sir.
8 **Q.** Okay. You mentioned that he had multiple stressors
9 from his family and that seemed to be something that was
10 impacting his presentation. Do you recall what he was saying
11 about his family situation and how that was impacting him?
12 **A.** A lot of it centered around his relationship with his
13 wife and family at large, so that took up a lot of his
14 preoccupation as well, a lot of what he was most worried about.
15 **Q.** Okay. You say, in I guess the largest paragraph there
16 on the first page, you said, "Even while ..." This is about
17 halfway through that paragraph. You said, "Even while talking
18 to me, he was quite frequently preoccupied with random details
19 of his traumatic experiences and admitted he was beginning to
20 feel quite paranoid and unsafe in himself." That paranoia, was
21 that evident to you when you were talking to him and is that
22 something that you could observe from your interaction with him?

1 **A.** Yes, I did observe some of that in my interaction with
2 him, yes.
3 **Q.** Do you have a sense now, or a memory, of what he was
4 primarily paranoid about?
5 **A.** And that was the ... maybe I should ... I could almost
6 say I use paranoia interchangeably with suspicious because
7 paranoia in itself, again, is a psychiatric terminology that's
8 supposed to define a delusional state.
9 **Q.** Yes.
10 **A.** And there is some difference between being suspicious
11 or what we call having overvalued ideas, even though they may be
12 paranoid ideas shown versus having a completely delusional idea
13 shown. And the difference, essentially, is that in delusions,
14 they are usually firm, they are completely unshakeable and you
15 can't get them off it. You can't challenge it, you can't push
16 back on it.
17 So I didn't think, in my assessment and in my interaction,
18 I wasn't convinced he was full-on delusional, but there clearly
19 were paranoid thoughts, paranoid-type ideas, suspicious ... of a
20 suspicious nature, yes.
21 **Q.** So without frank delusions, the unshakeable beliefs,
22 you perhaps would not diagnose him as having a psychosis, but he

1 did have what you, I guess, measured as overvalued suspicions.
2 Is that ...
3 **A.** Yes, I would say that. Yes, sir.
4 **Q.** And those sort of overvalued thoughts or suspicions,
5 what were those in relation to, primarily?
6 **A.** Again, in relation to his wife and in relation to,
7 say, his safety. He had been engaged ... he reported a lot of
8 issues at the workplace. He talked about bullying, he talked
9 about racial harassment and things like that, so it was always
10 in relation to some of that as well as his wife and his wife's
11 family.
12 **Q.** Okay. You note that he did work with Wendy Rogers,
13 who was a psychologist for the Canadian Armed Forces, for two-
14 and-a-half years on his trauma symptoms but admitted he was slow
15 to open up. I appreciate this was only your first meeting with
16 him but did you get a sense if he was a person who was guarded
17 about his symptoms and his illness or was he freer to open up?
18 **A.** With the military folks, it's a little bit more
19 difficult because when they are still in service, predominantly,
20 there is a level of guardedness in terms of how much of their
21 symptoms they would be open about while they are still in
22 service. And that's often because they have a fear of what it

1 might mean for their careers.
2 **Q.** Yes.
3 **A.** So in that sense, he wasn't very different from most
4 people coming from, you know, just recently being discharged.
5 **Q.** So his presentation in that sense was typical of
6 soldiers that you had seen or former soldiers?
7 **A.** In the sense of how open he was in therapy, yes.
8 **Q.** Yes, that's right. Is that difficult ... when you're
9 speaking to a patient and perhaps even moreso for the therapist,
10 the psychologist, but is it difficult to break down those
11 barriers sometimes amongst military people, that guardedness?
12 **A.** It is ... it can be difficult but, equally, we are
13 somewhat on the other side of the fence. So that probably gives
14 us a little bit of a cache and acceptability to them. So it's
15 all about building the rapport, encouraging engagement, and
16 letting them know that we're actually different and, you know,
17 they need not have those kind of apprehensions in terms of being
18 open to us.
19 **Q.** Okay. His past medical history, you mentioned that he
20 complained of chronic back pain and you talked about injuries
21 that he had sustained, including a fall he had from ten feet
22 onto his back, and also having been involved in an LAV rollover

1 where he sustained soft tissue injuries only to his neck. So a
2 couple of questions about chronic pain. When you're dealing
3 with a patient who has PTSD and other conditions, if they are
4 also suffering from physical pain, chronic pain, perhaps from
5 injuries, does that pose a challenge, I guess, to dealing with
6 their mental health conditions as well?
7 **A.** It does and it would also depend on the correlation
8 between the injuries sustained and their primary trauma event.
9 So where the injury was part of their trauma experience, then
10 they become interwoven. So each time, pain kind of would be a
11 retrigger for his trauma symptoms. So in that case, it actually
12 makes it so much worse. Or even at baseline, even where there
13 isn't a direct correlation, pain is always a compounding factor.
14 **(10:30)**
15 **Q.** Right. And I would assume it has some impact on ...
16 If someone is being treated pharmaceutically for pain and then
17 you're giving them other medications for their mental health
18 conditions, that can be ... I guess pose a challenge as well,
19 could it?
20 **A.** It could, yes, sir.
21 **Q.** Right. When you saw Lionel Desmond on this day, did
22 you have any sense of whether there was any risk of suicide?

1 And I guess more generally I would ask that's something that you
2 assess, do you, or talk to the patient about?
3 **A.** Yes, we do. We would. Of course part of the process
4 of looking through his previous notes would capture that. So if
5 there's a past history of suicide or suicidal ideation or
6 suicidal type behaviours, that will be captured in his previous
7 notes.
8 We would offer ... we would ask directly, Are you suicidal
9 currently? Do you feel life is worth living, you know, that
10 sort of thing. Do you have any plans? Do you ... have you ever
11 acted on it? What are your protective factors? What stopped
12 you from doing this? So I would have gone through all of that
13 with him.
14 **Q.** If a patient presented as, in your opinion, posing a
15 risk for suicide on an assessment such as this, what would you
16 do typically to deal with that?
17 **A.** It would probably depend on the severity of risk that
18 I have identified. At the very upper most severe levels I would
19 be wanting the patient to be admitted into hospital likely
20 involuntarily, even if he refuses to go in voluntarily.
21 At a less, at a lower level of severity I could negotiate
22 with him, I could offer a hospital admission. But even if he

1 refuses it it wouldn't necessarily compel me to admit him
2 involuntarily. At that point, I'd probably be working out okay,
3 what protective factors can we put in place, what supports, can
4 you reach out. You know, would you identify if you're relapsing
5 or if there's much higher likelihood of acting out. So it would
6 really depend on the level of severity of risk.
7 **Q.** Okay. In Lionel Desmond's case, you did not see any
8 risk of suicide on that first visit?
9 **A.** No, sir, I didn't.
10 **Q.** Okay ...
11 **A.** Again, if I may just ... sorry. If I may just read my
12 ... some of my notes. I think if anything, it was even more
13 around the homicidal threats that he had periodically made.
14 **Q.** Yes, and ...
15 **A.** So that's even what I fixated a lot more on them
16 because he clearly had made those threats.
17 Well, as the suicidal intention, I had asked directly and
18 he says no. I checked in his notes and I hadn't picked up on
19 any previous history, so that was more subdued in terms of my
20 area of concern. It is the homicidal threats that I kind of
21 looked at a little bit more closely.
22 **Q.** Right. So in the ... just in the section that says:

1 "Mental State Examination" you say:

2 On account of his agitation, he used a lot
3 of swear words, he made verbal threats
4 against (and it says 'unarmed' but it's
5 corrected to 'unnamed') others, but was ...

6 **A.** Yes, sir.

7 **Q.** ... difficult to establish any strong intent
8 behind any of the threats uttered.

9 So he made verbal threats against unnamed others. Do you
10 remember the context in which he made those threats? In other
11 words, what he was talking about when he became that angry to
12 make those threats?

13 **A.** If I recall right, it would have been when he was pre-
14 occupied with, you know, describing things. So sometimes it
15 would be related to people who had harassed him in the military.
16 So his experience of harassment. And then sometimes it would be
17 related to his experience in the war zone in Afghanistan.

18 **Q.** Okay. How specific was he in terms of those threats?
19 I appreciate you say you didn't see any strong intent but do you
20 remember how he would phrase it or what he was saying?

21 **A.** Honestly just now I can't recall the exact phrasing he
22 would use, no.

1 **Q.** Okay. If a threat was made by a patient that was more
2 specific that, as you say here, might have had some intent
3 behind it or appeared to, like I'm going to go and, you know,
4 harm somebody, what would you do if a patient expressed those
5 thoughts to you?
6 **A.** So there are two parts to it. It would be what would
7 I do with the patient and around the patient, and that would
8 include assessing the degree of intent, assessing the degree of
9 risk, assessing the possession of means and all that. And also
10 determining how much of this is mental health; how much of it is
11 just his personality type of thing. If it's most purely mental
12 health then that's a pathway for a hospital admission most
13 likely.
14 Now, if at all, on the other hand once I've done or managed
15 the patient, I also have a duty of care to report if they intend
16 and the threat was quite very specific about certain people
17 there's a duty of care for us to report that as well.
18 **Q.** Okay. And his threats and his comments didn't rise to
19 that level then, in that first meeting?
20 **A.** No, it didn't, sir.
21 **Q.** Okay.
22 **A.** Not by my assessment then, no.

1 **Q.** Sure. You also said there were a few dissociative
2 episodes, though, whilst here particularly during moments of
3 retelling his trauma accounts. Can you describe what you mean
4 by a dissociative episode and how those appeared in Lionel
5 Desmond?
6 **A.** So a dissociative episode is more like an extreme form
7 of re-living symptoms. Re-living is one of the core PTSD
8 symptoms that people will present with. And when they are re-
9 living they are pre-occupied with memories or thoughts or
10 images. Sometimes it gets very extreme, in which case as they
11 re-live they feel as if they are back in time, back in the place
12 of the trauma event, and at that extreme point that's what ...
13 that's what will present as a dissociation.
14 So when they are disassociating they will be either in
15 Afghanistan or responding as if they are in Afghanistan or
16 responding as if they are under fire. And, of course, like
17 everything else, probably there's a whole spectrum of that kind
18 of presentation.
19 So that's exactly what happened with him. I might be
20 asking him about what did you have for breakfast or what was
21 your day like and then ... so then he flips or flips in there
22 and he's talking about being attacked or talking about the

1 bodies or the bodybags.
2 And so the hallmark of PTSD is that people get distressed
3 by this intrusive imagery or intrusive memories where they do
4 not have any control over it and where they do not necessarily
5 want to ... it's not quite the same as a regular recall or a
6 regular memory that you want to pull out. So that's what I
7 meant by the dissociative experiences.
8 **Q.** How long would those dissociative episodes typically
9 last? Well, let me ask you about your meeting with Lionel
10 Desmond. How long did his last?
11 **A.** So his would last anything for usually a few minutes.
12 **Q.** Yes.
13 **A.** Usually. But in that time he's completely veered off
14 from what you are having a conversation about, you probably have
15 to stabilize or calm or bring him right back down and bring him
16 back to the present.
17 **Q.** Would a patient typically become more agitated when
18 they're having a dissociative episode like that?
19 **A.** They could, yes.
20 **Q.** How do you bring them back or calm them down?
21 **A.** We describe it as grounding. So, again, the concept
22 is that you're removed from the present and you're back in time,

1 so the idea of grounding is to bring you back to the present.
2 And the very crudest way might be something like smelling salts,
3 the old school smelling salts. So the idea of that is that that
4 snaps you back. In a clinical setting I clearly didn't have
5 smelling salts so it would be just about talking him down and
6 reminding him and bringing him back to his meeting with me.
7 **(10:40)**
8 **Q.** Now you said overall you were concerned about his
9 presentation not sufficient for him to be formally admitted
10 involuntarily to hospital, though while at least enough to
11 believe he really would benefit from residential treatment.
12 I take it from that that you at least thought about the
13 idea even of an involuntary hospitalization, although his
14 condition was not such to warrant that but that was something
15 that was on your mind, was it?
16 **A.** Yes, sir.
17 **Q.** Okay.
18 **A.** Yes, I did think about it ...
19 **Q.** Okay.
20 **A.** ... and I discussed it with him. But not involuntary;
21 I discussed options.
22 **Q.** I think early on when we talked about how these ...

1 the form that these meeting would take, you said, I believe you
2 did, that you would talk about goals or treatment with the
3 patient.
4 Did you have that conversation with him and did you have a
5 sense from him what he wanted to achieve and what he thought his
6 treatment should like?
7 **A.** Not in specific terms, it was more general: I just
8 want to get better; I want to stop feeling this way.
9 **Q.** And you felt a residential treatment program would be
10 appropriate for him?
11 **A.** I did, sir, yes.
12 **Q.** At that point in August of 2015, did you have a sense
13 of what residential treatment program would be right for him or
14 what the options would be?
15 **A.** So we have limited number of residential programs that
16 are specifically geared towards veterans and RCMP population
17 group. We have a couple in ... we have one in Montreal and then
18 we have a couple in Ontario. There is another one out in BC.
19 So those are the resources we would normally use.
20 The idea of a residential program is somewhat different
21 from having him admitted in to, say, the regular psychiatric
22 hospital here in Fredericton. So that would be something, say,

1 if he was suicidal or if he was hyperaggressive or of
2 significant risk to others, then I would have been talking of an
3 admission here.
4 But usually a hospital here is more for an acute admission
5 and treatment process, whereas PTSD requires much, much more
6 prolonged and specialized treatment which is something offered
7 at any of those four places.
8 So usually once we've identified that he's better off in
9 that kind of residential treatment, we'd normally then liaise
10 with Veterans Affairs again and the case manager, who would then
11 sort of start looking around and figuring who is free, who is
12 ... who has openings, what population ... sometimes we have to
13 think about the population group in treatment at that time, some
14 don't mix too well, so all of that.
15 Sometimes we are looking for a concurrent treatment program
16 if perhaps you're worrying about comorbid substance use disorder
17 and all of those will go in to determining which would be a best
18 fit for him.
19 **Q.** Sure. So the benefit of a residential program you
20 said it's prolonged and specialized, I guess, for treating
21 patients?
22 **A.** For treating PTSD patients.

1 **Q.** PTSD patients.
2 **A.** And for treating veteran PTSD patients or RCMP PTSD
3 patients.
4 **Q.** And you felt that that form of treatment, the
5 residential treatment route, was something that was necessary
6 for him and appropriate?
7 **A.** Yes, sir, I did.
8 **Q.** Is that because of the severity of his condition or
9 were there other factors that made you think residential
10 treatment would be right for him?
11 **A.** It was because of the severity of his condition.
12 **Q.** And typically ...
13 **A.** And as well ... sorry, just to add though.
14 **Q.** Go ahead.
15 **A.** It was about the severity of his condition as well as
16 the identified trouble we had already picked up on in terms of
17 how difficult it was for him to even engage consistently with us
18 in the community. So the idea would be, okay, if you could go
19 in there, have a consistent, you know, closed sort of treatment
20 program that should stabilize you up to a point that you can
21 then ... we could pick things up once you're discharged.
22 **Q.** So even at that point in August of 2015, your clinic

1 felt that it had some difficulty engaging with him in the
2 community just in terms of appointments, that type of thing?
3 **A.** Yes, even at that point. Because I think ... I
4 believe Dr. Murgatroyd had already been expressing some of that
5 by then.
6 **Q.** Do I take from what you said that structure then was
7 something that was important for his success in treatment? A
8 structured program?
9 **A.** Yes, sir. Yes.
10 **Q.** You said that the residential treatment program would
11 assist in stabilization. What did you mean by that term?
12 **A.** So stabilization would include ... actually, it would
13 include medications. Get him consistently on medications. It
14 would include psychoeducation. Learning about his trauma.
15 Learning about the triggers. Learning about how to manage some
16 of his worst symptoms, his aggression, his sleep, his
17 nightmares, his anxiety. All of that comes with stabilization.
18 But that's different from even going to trauma specific
19 treatment. So you need to have done the stabilization piece
20 first. You need to have the skills to self-regulate and to
21 self- soothe before you go on to full-on trauma processing
22 treatment.

1 **Q.** Okay. And so before the trauma therapy is even going
2 to be successful, stabilization has to happen first?
3 **A.** Yes, sir. True.
4 **Q.** And would you say he was in a place, at the time that
5 you saw him, where he required stabilization? He was not in a
6 stable situation?
7 **A.** No, he was not. I would say so, yes.
8 **Q.** Did you have a sense at that time how long the
9 residential treatment program should be or what would be
10 appropriate for him?
11 **A.** So each of the residential treatment places do have
12 set program times. So sometimes what we want is for them to at
13 least complete it, then we are present, we'll reassess. Some
14 people have been known to go back.
15 **Q.** Yes.
16 **A.** Some people need to, say, top up and some of it we
17 would carry ... we would be in a position to carry on in the
18 community. So there, I think Ste. Anne's was six ... was eight
19 weeks I believe, Ste. Anne's.
20 **Q.** If you were to make a recommendation for residential
21 treatment knowing the various programs, would you make the
22 recommendation to Veterans Affairs Canada or how would that

1 process take place?

2 **A.** If we had a specific requirement yes, we'd make a
3 recommendation to Veterans. So like I said, if we had somebody
4 who specifically needed a concurrent treatment, he needed to
5 work on his PTSD as well as his drug use, right, we would do
6 that. Or there's PTSD mixed with significant personality
7 disorder there are some programs that are stronger on one and
8 perhaps not the other. And, indeed, some programs don't
9 necessarily run both.

10 **Q.** Ultimately, he went to Ste. Anne's. Was that a
11 program that you thought was appropriate for him?

12 **A.** I thought so. Yes, sir.

13 **Q.** And why was that one a good one for him?

14 **A.** Because Ste. Anne's at the time was purely dedicated
15 to working with veterans. We had sent and had received back
16 quite successful admissions or referrals who had done very well
17 from the program. We had a close communication with them as
18 well. In fact, I had been there before so I knew what kind of
19 program they were running and what was on offer.

20 **Q.** Okay. All right. Now you made a diagnosis. You said
21 you felt he had chronic PTSD quite severe, major depressive
22 disorder and comorbid alcohol use disorder. So, I guess, you

1 concurred in the diagnosis that he had received from the
2 Canadian Armed Forces; that is, the PTSD and a major depressive
3 disorder?
4 **A.** Yes, sir.
5 **Q.** What did you find about his alcohol ...
6 **A.** This was certainly my ...
7 **Q.** Yeah, go ahead.
8 **A.** Sorry. No, I said this was certainly my own
9 diagnosis, yes.
10 **Q.** And you also diagnosed him with an alcohol use
11 disorder. What did you learn about his alcohol use that caused
12 you to diagnose him with an alcohol problem?
13 **(10:50)**
14 **A.** I learned his drinking had increased progressively. I
15 learned essentially that he hadn't actually been drinking prior
16 to his return back from Afghanistan. I learned, and indeed he
17 said, his drinking was a way of coping and managing his
18 symptoms. And again, that's something we tend to see quite
19 often. And I learned he was drinking I think about 12 drinks a
20 day, I believe. So all together I thought there as a
21 significant alcohol use problem.
22 **Q.** Is the use of alcohol perhaps to self-medicate, but in

DR. ANTHONY NJOKU, Direct Examination

1 any event, the use of alcohol often a problem with patients with
2 PTSD? A comorbid problem?
3 **A.** It can be a comorbid problem, but for sure most people
4 who do have increased use of alcohol as a way of self-
5 medicating. It doesn't necessarily always rise to the point of
6 an alcohol use disorder but it certainly is the case.
7 **Q.** Now you didn't make a change to his medication at that
8 time. You do make a note. You say: "He was not keen to
9 consider a reduction of his medicinal marijuana which may
10 actually be further exacerbating his agitation and worsening
11 symptoms."
12 So at the time you saw him he was using medical marijuana,
13 was he?
14 **A.** Yes.
15 **Q.** You were concerned about that exacerbating some of his
16 symptoms?
17 **A.** Yes, I was.
18 **Q.** And what is your experience with patients who use
19 medical marijuana and what risks are associated with it?
20 **A.** My experience has varied over the years with all the
21 recent changes on how that sort of evolved. But in terms of the
22 associated risk, I've always worried about people who already

1 have any addictive concerns, any trouble with addictions being
2 on marijuana. So that's one risk because of the addiction.
3 I do ... it certainly does ... it can worsen agitation. It
4 can worsen paranoia. It can set off psychosis in some cases or
5 exacerbate already existing psychosis. And those are my primary
6 concerns about it.
7 **Q.** Did you make a recommendation to him about whether he
8 should continue with medical marijuana or not?
9 **A.** He wasn't keen on reducing it. He wasn't. So we
10 discussed ...
11 **Q.** Did you have thought about whether he should?
12 **A.** No, no. Yes, that's what I meant. Sorry. So we did
13 discuss it but he didn't want to reduce it, so he wasn't
14 consider- ... he wasn't open to that as a plan.
15 **Q.** Okay. Did he seem open to other forms of treatment,
16 for example, the residential treatment at that stage?
17 **A.** Honestly, he didn't jump at it, no. He wasn't ...
18 just to put it in context, again, this was the very first
19 meeting.
20 **Q.** Sure.
21 **A.** This is somebody who has just transferred from being
22 in service all these years and suddenly he's been transferred to

1 a community-based service. He was meeting me for the very first
2 time. He's not always been open, as he pointed out. So it was
3 already a difficult sort of ask to expect him all of a sudden to
4 accept that kind of thing.
5 So at that point, honestly the best I was hoping for was to
6 at least have it on the table, plant a seed as we might say, and
7 then hopefully keep building on that.
8 **Q.** Right. Okay.
9 **A.** But when I put it on the table, he wasn't accepting of
10 it at that time.
11 **Q.** Okay.
12 **A.** He didn't throw it out; but he didn't accept it.
13 **Q.** Right. Understood. You said that you thought he
14 required urgent follow-up. Flowing from that initial meeting,
15 what did you think should happen in the short term going
16 forward?
17 **A.** So besides seeing me he was already also seeing Dr.
18 Murgatroyd for therapy, so between both of us I thought offering
19 him a three-week appointment was going to be a decent enough
20 spacing.
21 The other point that we had considered was that we were
22 going to discuss and agree to approach VAC so they could offer

1 him some extra support in the community. So like we were
2 pointing out earlier, when it came to things like not having
3 clear structures, not being able to organize, can he ... does he
4 need reminders of appointments, can we put that in place, you
5 know, all of that.
6 So we thought it would be easiest to sort of support that
7 by offering a clinical care manager. So that was the extra
8 thing we were working on.
9 **Q**. Okay. So, just following up on that, you said: "I
10 will be seeing him at that point. I plan to review his case at
11 our IDT meeting with a view to exploring other more conjoint
12 ways of supporting this veteran at home, which I think is at
13 significant risk and is clearly quite ill at the moment."
14 So someone in the community, like a clinical care manager,
15 someone to organize him a bit, you saw that as a need for him,
16 did you?
17 **A**. I thought that would be a need, yes.
18 **Q**. Were you aware if there was such a person at that
19 time?
20 **A**. I don't think there was. No, I didn't think there
21 was. He had a case manager ...
22 **Q**. Yes.

1 **A.** ... but I didn't think he had a clinical care manager
2 then.
3 **Q.** Is that sometimes a problem for patients that you see
4 from a military background with PTSD, that they need that form
5 of structure or organization or assistance in structuring and
6 organizing their lives?
7 **A.** Yes, again, because of the severity. Say, for
8 instance, he's ... if he's so disorganized. If he was that pre-
9 occupied even talking to me, one can easily imagine what it
10 would like for him at home. I could easily imagine how
11 difficult it would be for him to even stay on task in terms of
12 taking his medications or in terms of following through with
13 appointments or paperwork or any of these several things. Now
14 he had his hands full anyway, you know, he had all this
15 financial stuff. He had his relationship stuff. He was trying
16 to move. So there was a lot going on for him as well.
17 **Q.** Right. And even self care perhaps might be
18 compromised if a person is that ill?
19 **A.** Yes, sir, it could be.
20 **Q.** Typically ... Well, I say typically and I know every
21 case is unique, but in this case you said you wanted to see him
22 I think within three weeks. Why did you think it was important

1 for you to see him within three weeks?

2 **A.** Well, I would have to balance how urgently he was

3 presenting. Three weeks would normally be the average. Say,

4 for instance, if I had ... I didn't, but if I started a new

5 medication I would give it about three weeks, particularly an

6 antidepressant, by which time I will be able to figure out

7 exactly what's happening or what changes are going on.

8 But in his instance, because he was seeing Dr. Murgatroyd

9 in between, and because he was already struggling to even make

10 several appointments, and on balance also considering how ill I

11 thought he was, I figured three weeks was probably just about

12 what I should offer. As it turned out, even that he struggled

13 to keep anyway.

14 **Q.** Okay. And I guess following up on that, you saw him

15 on August 31st. Would you typically give or would staff give a

16 patient another appointment date right there?

17 **A.** Yes, sir. Yes.

18 **Q.** Okay. Our next note is from December 3rd, 2015. So

19 were there appointments scheduled between August 31st and

20 December 3rd that he didn't attend?

21 **A.** Yes, sir. So they gave him one for three weeks but he

22 didn't keep it.

DR. ANTHONY NJOKU, Direct Examination

1 **Q.** And what would normally happen if you give a veteran
2 an appointment, say, in three weeks and they don't attend, is
3 there follow-up with them to see what's going on? What normally
4 happens?
5 **(11:00)**
6 **A.** There would be. There would be follow-up to see
7 what's going on. There would be an attempt to re-book or to
8 reassign another date. So that's what normally would happen.
9 Again, like, in his case, if I recall, I think there were
10 conversations with Dr. Murgatroyd and Dr. Murgatroyd had been in
11 contact and I think he'd gone ... Let me just be sure, if I
12 could. I believe he had traveled. He had gone back to
13 Antigonish at the time and that was the explanation but ...
14 **Q.** So there was a certain ... I guess his personal
15 circumstances were somewhat in flux then in terms of his living
16 situation and where he would be physically?
17 **A.** Yes, sir, it was. It was a significant issue, yes.
18 **Q.** Right. So you saw him next on December 3rd, 2015, and
19 your note from that visit is on page 31 of the exhibit. How did
20 he appear to you on the 3rd of December as compared to when you
21 saw him on August 31st?
22 **A.** So even then he wasn't, like, again, I was saying

1 there, he wasn't that much different. He still was rather
2 challenging and difficult to engage with completely. Very
3 irritable, quite angry. He was giving me feedback again about
4 several arguments with his wife. And overall, as I said, using
5 the word "hyperarousal", he was quite on edge, basically.
6 **Q.** Did you have a sense if the medications that had been
7 prescribed, if, number one, he was taking them, and if, number
8 two, they were of any benefit in treating his symptoms?
9 **A.** Further down, I'd said, I think the third paragraph,
10 that he had stopped taking the medications. He didn't think
11 they were helpful really.
12 **Q.** Right.
13 **A.** And instead he had now kind of gone over to the
14 marijuana and was completely putting all his faith in that. So
15 yes.
16 **Q.** And do you recall if he said when he stopped taking
17 the prescribed medications?
18 **A.** No. No, I don't recall exactly when he said.
19 **Q.** Okay. So the medications that were prescribed were to
20 treat what are apparently very severe symptoms and necessary for
21 successful psychotherapy. Did you have a concern that he had,
22 kind of on his own, stopped taking his prescribed medication?

1 **A.** I was certainly concerned about it, yes, and discussed
2 it with him.
3 **Q.** Do you recall if he was open to taking prescribed
4 medication again or was he resistant to it?
5 **A.** At the time, resistant to it.
6 **Q.** Okay. Now there is reference in this note on December
7 3rd, 2015, to an event that had occurred a short time before
8 that where the police had been called to his house and we've
9 heard evidence about that and you describe that in the second
10 paragraph of your note. Do you recall what he said to you about
11 that incident with the police?
12 **A.** He, if I recall ... again, I probably can't recall his
13 exact words.
14 **Q.** No, I understand.
15 **A.** But if I do recall, if I do recall correctly, his
16 impression was it was his wife that day had misunderstood the
17 discussion he was having with them and that they were trying to
18 get him into trouble and they had instead gone and called the
19 police and the police had taken away his guns and now he
20 probably has a record. So it was that sort of thought process
21 that he gave but he didn't see it in the light of "I was a
22 risk".

1 **Q.** Okay. So from what you've said, it sounds like he was
2 perhaps rationalizing his behaviour or what happened a bit?
3 **A.** At the time, honestly, it was next to difficult for me
4 to figure out is he rationalizing or is this legitimately the
5 out- ... the events as happened. On the flipside, I had to
6 balance that against the fact that he was seen in the emergency
7 room and he was discharged home which, in itself, indicates that
8 perhaps they didn't have that level of concern or they didn't
9 have that concern at the time.
10 **Q.** The fact that he was taken to the emergency room but
11 subsequently released, what did that tell you?
12 **A.** That's what I mean. That probably indicated that they
13 did not identify significant risk of harm to self or others.
14 **Q.** Knowing that this event happened, did you explore the
15 issue of suicidality with him in more depth on that particular
16 day to see kind of where he was and what risk he may have had?
17 **A.** I did. He denied he was suicidal then and denied any
18 suicidality at the time as well, at the time of assessment.
19 **Q.** Right. I guess at what point do you feel comfortable
20 that you can accept that, that he maybe doesn't pose a suicide
21 risk despite this event having taken place?
22 **A.** I'm sorry, I'm not sure I understand exactly.

1 **Q.** Given that he was taken by police to hospital, even
2 though he's telling you that he wasn't suicidal, I assume, but
3 correct me if I'm wrong, that you need to kind of dig a little
4 bit deeper to really feel comfortable that that's the case,
5 that, in fact, he doesn't pose a greater suicide risk?
6 **A.** I believe I did.
7 **Q.** Okay. And did you have a sense if he was at a higher
8 risk for suicide on that day, given what you talked to him
9 about?
10 **A.** No, I didn't think he was.
11 **Q.** Okay. You say that: "His presentation remained
12 challenging and he exhibited anger or being irritable." You
13 said: "It's quite difficult to tell how much of this is purely
14 their own relationship difficulties as against his hyperarousal
15 from PTSD." Were you able to kind of assess how much of his
16 symptoms and his irritation and anger related to his marriage
17 and how much were more purely symptoms of his PTSD?
18 **A.** I was never able to distinctly sort of make that call,
19 no. And indeed, it got even more ... it kind of got more
20 complicated for me when I did see her and the presentation was
21 at odds with a lot of all of this feedback I kept getting
22 periodically from him. So when I did see her, they seemed like

1 a normal couple, frankly.

2 **Q.** Okay.

3 **A.** So it was always a challenge. It was always sort of

4 something I was struggling with at each point.

5 **Q.** Right.

6 **A.** He was hyperaroused from his PTSD. There's no

7 question about that. That was always there and it was obvious,

8 but it's the preoccupation with his wife and, Oh, she's spent

9 all my money or she's done this or she's ... that was a piece I

10 wasn't sure. Is this because of the relationship simply

11 breaking down or is this now his trauma symptoms and

12 hyperarousal superimposing and exaggerating what is already a

13 relationship problem?

14 **Q.** And you also said a little further down that

15 paragraph: "He continues to express very strong belief that he

16 was the victim of several incidents of racism while at work. He

17 feels he was mistreated by the military." Was that something

18 that was, I guess maybe I'll use the word "ruminating" and

19 something that he continued to return to, his feeling of having

20 been mistreated by the military?

21 **(11:10)**

22 **A.** Periodically, yes, yes. And the defence of

1 mistreatment generally, so that would come back again with his
2 preoccupation with his wife or her family. It was always about,
3 They don't treat me right. They don't ... they are
4 disrespectful or something like that.
5 **Q**. Okay. And just in the concluding paragraph, you said:
6 "At the moment, in spite of his level of distress and agitation,
7 I still feel perhaps he could be experiencing worsening symptoms
8 on account of the medicinal marijuana, but which equally might
9 be doing some good for him." So I take it from that, you had
10 perhaps mixed feelings about the benefits of medicinal
11 marijuana?
12 **A**. I did. Yes, sir.
13 **Q**. Can you expand on that a little bit? Why did you feel
14 that it might be doing him some good?
15 **A**. No, because at the time, he, even though he was
16 distressed, somewhat he was more ... he was a little bit more
17 subdued. So he was ... I don't know how to describe it. He
18 wasn't as agitated as previously.
19 **Q**. Okay.
20 **A**. So something seemed a little different and this was
21 also in spite of his having stopped medications which, again, I
22 would have anticipated should make him a lot more worse.

1 **Q.** Right.

2 **A.** So on balance, again, I had to sort of make sense of
3 his presentation against the backdrop of the fact that he was on
4 just simply marijuana and nothing else.

5 **Q.** Had he been open to the idea of returning to his
6 prescription medication, would you have wanted him to do that?

7 **A.** I would, yes. No, I would have wanted him back on the
8 medications, yes.

9 **Q.** Right. All right. And you did, I guess, revisit the
10 issue of a residential program because you said he was more open
11 to the idea of a residential treatment plan.

12 **A.** Yeah, yes.

13 **Q.** So was it Ste. Anne's that you were talking to him
14 about specifically or just, again, a little more generally about
15 a residential program?

16 **A.** At that time, I think I would have been talking more
17 specifically Ste. Anne.

18 **Q.** Okay. So that visit was on December 3rd, 2015, and
19 your next note with him is on January 4th, 2016, so just about a
20 month later. And that's on page 30, I guess, of the Exhibit
21 244. So I take it, were there appointments in between or was
22 that the next scheduled appointment about a month later?

1 **A.** It was the next appointment. Hang on. Sorry, let me
2 be sure. I think he'd missed ... he'd traveled. Yes, they had
3 traveled. They'd been away and had traveled to Regina, I
4 believe, and had only just come back, so that was the first
5 appointment we're able to get him in for.
6 **Q.** So ideally, how often would you have hoped to be
7 seeing him?
8 **A.** Ideally, I would have wanted to see him, at the very
9 least, every three weeks.
10 **Q.** So continuing ...
11 **A.** Considering he was also going to be seeing ... he
12 would have been seeing Dr. Murgatroyd as well in between.
13 **Q.** Right. But from your perspective, for seeing you,
14 every three weeks was the optimal amount of time?
15 **A.** Yes, sir.
16 **Q.** So on January 4th, you say that he was accompanied by
17 his wife. So let me ask you, generally, if you're able to see
18 or speak to the partner of a patient or spouse, is that
19 something you want to do if you can?
20 **A.** Yes. It would offer me collateral information. It
21 would give me quite a lot more than I can get specifically from
22 just talking to the client. Sometimes they have symptoms of ...

1 just responding to their questions, sharing information on how
2 they can best support him. It's also an opportunity for
3 psychoeducation. Listen, this isn't you, this is his illness,
4 this is what it might look like, you know, and you get all the
5 questions. Am I doing it right? I don't want to make it worse.
6 If I did this, is that okay? So it's quite an invaluable
7 opportunity usually. Moreso in his case, actually.
8 **Q.** And why do you say that, "moreso in his case"?
9 **A.** Where I had all these doubts. Because I had all these
10 doubts. I had all this confusion of, okay, how much of this is
11 a relationship problem? How much of this is you over, you know,
12 your symptoms overexaggerating this, and how much risk and what
13 are they thinking and are they as concerned as ... you know, all
14 of that was a perfect opportunity for me to assess that really.
15 **Q.** Okay. Do you recall how that came about? Did you
16 expect him to come with Shanna, his wife, or not?
17 **A.** No. He came in and he says, Oh ... and I think he was
18 just talking about them having been away and the fact that they
19 were here. I said, Are they here with you? He said they were
20 in the car. So I said, Could you call them in? I don't mind.
21 And he said, Sure. And that's how they came in.
22 **Q.** Okay. So you made some comments a moment ago ...

1 **A**. It was his wife and his daughter.
2 **Q**. Sorry, what was that? His wife ...
3 **A**. It was his wife and his daughter.
4 **Q**. His doctor was with him?
5 **FEMALE:** Daughter.
6 **MR. MURRAY:** Daughter. Okay, thank you.
7 **A**. Daughter.
8 **Q**. Okay, that makes more sense.
9 **A**. Daughter.
10 **Q**. And so you met with his wife, and you said a moment
11 ago or you commented on the impressions that you had of her and
12 of their relationship. What was your sense of it when they came
13 in together?
14 **A**. It was reassuring, actually. It was reassuring that I
15 saw a young couple. I saw she genuinely cared for him. So
16 again, that put ... paid to some of that beliefs about, Oh,
17 she's spending all my money. She wants to run me down. She's
18 ... you know, all of this stuff I used to get before. So this
19 was a family ... a wife who was just as caring, who was just as
20 interested in his well-being, and who was wanting to know what
21 was going on with his treatment and what my thoughts were.
22 His daughter was there. Interaction seemed entirely

1 appropriate. I mean between him and the daughter, entirely
2 loving. So yes, it's probably the worst moment of this whole
3 thing.
4 **Q.** Okay. She seemed engaged then in his treatment and
5 what was going on with his care?
6 **A.** Yes, sir, she was. Could I take a moment, please?
7 **Q.** Yes.
8 **A.** I'm sorry.
9 **Q.** No, that's quite understandable.
10 **THE COURT:** You know what I might suggest, Dr. Njoku, is
11 that we quite often take a break. We started at about 9:30 and
12 it's probably about 20 after 11. Perhaps we could take a break
13 for 20 minutes or so and then come back? It's 20 after now.
14 Maybe we'll come back about 20 to 12 if that's good for
15 everyone?
16 **A.** Yes, Your Honour. I'm sorry.
17 **THE COURT:** Yes, no worries, Dr. Njoku.
18 **A.** I'm sorry. Thank you.
19 **THE COURT:** We appreciate you being here, so we'll take
20 20 minutes. Thank you, everyone.
21 **COURT RECESSED (11:18 HRS)**
22 **COURT RESUMED (11:42 HRS.)**

1 **THE COURT**: Thank you, Dr. Njoku. Are you good to
2 continue, Dr. Njoku?
3 **A.** Yes, Your Honour. Thank you.
4 **THE COURT**: All right. Thank you. Mr. Murray?
5 **MR. MURRAY:** Thank you. Doctor, you're good to continue
6 now are you?
7 **A.** Yes, I am. Thanks.
8 **Q.** We think a lot about the impact that this has had on
9 the victims and their families and we sometimes forget that it
10 reaches many people who interacted with Lionel Desmond and with
11 his family, so your emotion is quite understandable.
12 You said before we broke, Doctor, that you saw him with his
13 wife, Shanna, and with his daughter and that their interactions
14 were, I think you said comforting to you at the time and they
15 were appropriate. Is that correct?
16 **A.** Yes, sir, it was.
17 **Q.** In your note from January 4th, you said it appeared
18 that he ... or he appeared less suspicious and paranoid and all
19 around seemed to do better. So what can you say about Lionel
20 Desmond's presentation on January 4th himself, how he appeared
21 to you and how his symptoms appeared on that day?
22 **A.** He certainly was a lot less agitated. He wasn't as

1 angry. In fact, I would have anticipated with all of his
2 previous pre-occupation with his wife and all the concerns and
3 complaints he'd raising or accusations he'd been raising against
4 her, I would have thought it would have been a very contentious
5 or difficult session with her being there but he came back,
6 asking questions, responding to me, he seemed entirely
7 appropriate. He seemed welcoming actually of it. So overall, I
8 really thought ... I was pleasantly surprised and I thought he
9 was a lot less agitated than I had expected.
10 When I say reassuring, I was actually even more reassured
11 for the family. More reassured in terms of their marriage.
12 Again, I had been ... I had literally believed it was on the
13 rocks, basically, but that showed well, maybe you've just come
14 back from a holiday. They both reported the holiday as being
15 probably the best they had in a very long time. They reported
16 that there were much fewer arguments through the holiday and
17 they really did have an opportunity to relax and be together.
18 So I came away really feeling better after that meeting.
19 **Q.** Did you have a sense of why they seemed to be doing
20 better together and why the holiday was helpful for them?
21 **A.** Well, honestly, it's hard to conjecture; it could be
22 any number of things. I thought it was also striking that

1 during that holiday and, indeed, he was open to talk to me. He
2 pointed that out that he'd cut back on his ... couldn't, he
3 didn't dare be caught, you know, intoxicated. So he had cut
4 back his marijuana. And then when he was there, it appeared he
5 hadn't been able to have ready access as well.
6 So I thought that was striking and I felt well, if ... this
7 might actually be ... I don't know, you know, this might be an
8 indication of how harmful, you know, marijuana use was to you.
9 So based on that I was actually able to go ahead and push for
10 him to cut back even further than what he was (inaudible - audio
11 skip) now he started (inaudible - audio skips) it. So once he
12 came back I'm going to now try and push that back.
13 He was still having nightmares, though, but it was less
14 than previously for sure. So that was what I really noted at
15 the time. And this time again, with the wife, they were now
16 both talking about being admitted.
17 One of the challenges we'd had about his going to ... his
18 acceptance, ready acceptance, to be admitted to a residential
19 program was how wound around his relationship things were. So we
20 were worried that he wouldn't want to be away from home if he
21 was this suspicious and he'll be thinking all kinds of stuff was
22 going on at home. But surprisingly, they were both in agreement

1 that this was the best course of treatment. She supported it.
2 And so it ... I think (inaudible - audio skip)...
3 **THE COURT**: We're going to stop.
4 **MR. RUSSELL:** Yeah.
5 **THE COURT**: Doctor, sorry ...
6 Sorry. Dr. Njoku, we have a connection issue at the moment
7 and both your audio and your video is breaking up.
8 **THE CLERK:** Can we hang up and redial again?
9 **THE COURT**: So I think what we're going to do to try and
10 solve the problem is we're just going to break the connection
11 with you for now and we're going to try and reconnect to see if
12 it comes through a little better. If you could just bear with
13 us for a moment.
14 **A**. Okay. Yes.
15 **THE COURT**: All right. Thank you.
16 And, Mr. Murray, when we come back with Dr. Njoku, I'm
17 going to try and get you to go back ...
18 **MR. RUSSELL:** I will.
19 **THE COURT**: ... if you could just to have him re-
20 highlight his evidence if you could, please.
21
22 **(CONNECTION RE-ESTABLISHED)**

DR. ANTHONY NJOKU, Direct Examination

1 **THE COURT**: So we have you back on the monitor, Dr.
2 Njoku. We'll start. Mr. Murray is going to take you back just
3 maybe a bit of review of what you had said. Because it's
4 important for us to have your impression of the relationship as
5 you saw it and how that might impact the look forward with
6 regard to Cpl. Desmond's ongoing treatment. Thank you.
7 Mr. Murray?
8 **A.** Yes, Your Honour.
9 **MR. MURRAY:** Thank you, Doctor. Yeah, just in the last
10 connection we got the gist of your answer, we got about 75
11 percent of it, but I'll just kind of go over this again just so
12 that we have a complete answer.
13 I was asking you about how Lionel Desmond and his wife
14 appeared to you I guess, and what you observed of them together
15 and how, in particular, he appeared as compared to before.
16 **A.** So I was saying that he appeared a lot more relaxed
17 than he had previously.
18 **(11:50)**
19 **Q.** Right.
20 **A.** Moreso considering that he was in there with his wife
21 and didn't seem as suspicious towards her and was more
22 accommodating and tolerant of her being able to give her own

1 feedback and basically seemed like a regular married to ... sort
2 of married couple.
3 However, even they admitted then that they were still
4 having some arguments, a lot less but that they still had
5 arguments coming in or driving down from Regina and all that so
6 that was still there. They haven't gone away completely. But
7 during the session they didn't have any arguments. He tolerated
8 her feedback and he was able to also speak appropriately.
9 So I left ... I was left with the impression of quite a
10 significant reassurance in terms of their marriage and in terms
11 of it also allowed me to sort of contexturalize a lot of what he
12 had previously been reporting. So at that point I'm beginning
13 to think well, okay, so yeah, it's like a couple having
14 problems, but this guy's probably overblowing it because of his
15 level of hyperarousal and making a lot more of it and perhaps
16 being a lot more suspicious as well.
17 **Q.** And when I asked you about his symptoms I think
18 appearing a little better and asked you to speculate I guess on
19 why that might be, did you have a sense of why his symptoms
20 might have seemed a bit better on January 4th?
21 **A.** So that's where I said I thought I was particularly
22 struck by the fact that he had ... he, himself, had pointed out

1 to me that he'd not been able to use as much marijuana during
2 the whole trip. First of all, driving down he couldn't afford
3 to be intoxicated or to be caught with a positive screen. And
4 whilst there, he didn't have ready access to as much as he
5 probably would have previously.
6 That was all he noted, but I thought that was a striking
7 point that he brought up and thought perhaps that led me to ...
8 that strengthened because I already had my premonition but that
9 strengthened my opinion that maybe the marijuana was certainly
10 exacerbating an already bad situation.
11 **Q.** Right.
12 **A.** And that perhaps encouraged me and gave me a little
13 bit of leeway to further urge him to cut back. He was already
14 ramping up a little but because he had come back and he was like
15 getting back to his normal patterns and I was trying to use that
16 as leverage to encourage him to cut back even further.
17 **Q.** Okay. And did he seem receptive to cutting back a
18 bit?
19 **A.** He did. I'm not sure if I mentioned that, yeah,
20 because I think it was at this point he started talking about
21 using predominantly CBD instead of the THC and trying to make
22 some of those changes. I don't ... I can't see that I put that

1 or wrote that specifically, but I think I kind of recall him
2 talking about using more CBD predominantly rather than THC.
3 **Q.** Right. And before we reconnected, you said that the
4 positive nature of your observations of their relationship gave
5 you some confidence about him going to a residential treatment
6 program?
7 **A.** I did. Confidence from her being there and her
8 obvious support for his residential admission. So clearly, both
9 of them could arrive at an agreement that this was best for you.
10 I had anticipated perhaps that there would be a little bit
11 of push back and previously we had encountered some resistence
12 from him, based on the fact that I can't leave my family, I want
13 to be with my wife, I'm trying to fix things. Or when he was
14 very agitated he would be, Oh my God, if I left she will finish
15 ... spend all my money or she will do all of that stuff.
16 So there were two sides of it, either when he was
17 (inaudible - audio skips) sick of his family or when he was
18 complaining because he was overly suspicious. So that was
19 really put to rest there because both of them were clearly in
20 agreement that this was the best course of action. So that was
21 a support for him and it was a support forcing pushing through
22 with the plan.

DR. ANTHONY NJOKU, Direct Examination

1 **Q.** Okay. You did say that he did appear still, despite
2 the improvement, jumpy and he was experiencing dissociative
3 episodes. Did you see that in the appointment or is that what
4 he self-reported? I was looking just mainly the lower part of
5 the first paragraph there.
6 **A.** Yes, that would be from his self-report.
7 **Q.** Okay.
8 **A.** That would be from his self-report. So from the
9 appointment himself I would have been stating on the mental
10 state examination how he presented and I would have been
11 reporting it but this was on his self-report.
12 **Q.** Right. Okay. So it appears in conclusion to this
13 report you say you're looking at pushing through a fast-tracked
14 appointment for inpatient treatment at Ste. Anne's. So it seems
15 as though he's onboard now with going to Ste. Anne's?
16 **A.** Yes, sir. Yes. His wife as well, which was a bonus.
17 **Q.** Did you have a sense at that time of how quickly a
18 person could get into a residential program like Ste. Anne's
19 even with a fast-tracked intake?
20 **A.** No. No. It's never ... it's never as fast as fast-
21 tracked might assume. So again, like I said, it's quite
22 different from an admission, it would depend on where they are

1 in terms of the cycle of treatment. It would depend on how much
2 free space they have to take people on.
3 So those usually ... in his case I think eventually when he
4 did get on, it took about three weeks from when we all agreed
5 and called them again and when they were able to set it all up.
6 So it's the luck of the draw, unfortunately.
7 **Q.** I see. Okay. So in the meantime, though, you were
8 ... the plan was to continue to see him approximately every
9 three weeks?
10 **A.** Yes, sir.
11 **Q.** Okay. We've been told that and we've learned that to
12 be admitted to Ste. Anne's one can't be using marijuana at all.
13 Was he aware of that when you were discussing that with him,
14 that he would have to cut out his marijuana use?
15 **A.** He was. So again, on the first paragraph, it was the
16 last piece of it on the positive side: "He's quite keen to
17 follow through with the admission and he knows while he's away
18 he will not be allowed the use of marijuana and seemed willing
19 to work with this."
20 **Q.** Okay.
21 **A.** So that conversation had already started. Dr.
22 Murgatroyd was also using the same sort of tack and we are kind

1 of trying to prepare him all along.

2 **Q.** All right. So you saw him again then on the 27th of
3 January 2016, this one is on page 29 of the exhibit. It would
4 appear that he's still struggling with his PTSD symptoms.

5 Did you notice any significant change in the period of time
6 between the 4th and the 27th of January?

7 **A.** So the main thing ... again, going by my notes I'm
8 kind of jogging my memory with that. The main thing was about
9 an event that happened while he was ... his mom-in-law and his
10 wife while they were at home, so it looked like there was ... he
11 reported that there was particular incident where he
12 overreacted, he became much more agitated, but then explained
13 this was because he was at the time still living close to the
14 base or within the base and was regularly overhearing overflying
15 aircraft, he would hear, you know, gunshots, he would hear, you
16 know, from training and all that from the training or exercise
17 grounds and that continued to leave him triggered, jumpy and
18 hyperagitated. So that was the one incident that he explained
19 to me specifically.

20 And again, this probably was because he was with his mom
21 and his ... with his mother-in-law and his wife. So that was
22 the one thing that stood out. But beyond that again, I thought

1 he was kind of maintaining that trajectory of some settling, not
2 the greatest, but some settling still.
3 **Q.** Okay. He's still not on any medication. Again, was
4 this ...
5 **A.** Yeah.
6 **Q.** ... something that he was resistant to, going back on
7 prescription medication?
8 **(12:00)**
9 **A.** He was still resistant at this point, yes.
10 **Q.** Okay. And you said: "He probably needs to do some
11 more work on basic stabilization and grounding skills to cope
12 with some of his more hypervigilant and hyperarousal symptoms,
13 and again, more psychoeducation."
14 Was your thought that that's something that he should be
15 doing then or something that would happen when he went to Ste.
16 Anne's?
17 **A.** If I may say, all of the above.
18 **Q.** Right.
19 **A.** So it was something he should have done long since.
20 Something he should have gained from previous therapy which, for
21 some reason he hadn't. It was something we are actively trying
22 to do which we still couldn't get him to.

1 So, for instance, his jumpiness and the way he was reacting
2 to the mortar fire, at that point one would have expected that
3 he would have understood the correlation, okay, this is because
4 of this noise and all right, it's okay, right.
5 And then the grounding is a basic skill that is a primary
6 skill that we normally would teach because that helps ground
7 you. He clearly hadn't begun ... or at least he wasn't using
8 them at the time clearly and always seemed surprised at some of
9 his symptoms and then that wasn't its impact on him.
10 So it was a bit of me pointing out perhaps I'm wondering
11 why this was still an issue but highlighting that this would
12 certainly need to be corrected in his stablization treatment at
13 Ste. Anne's.
14 **Q.** What are some of the grounding skills that a person
15 with PTSD can use to deal with their symptoms?
16 **A.** So it is more to the same as the dissociative one.
17 Remember when I was describing dissociation? So one would be if
18 you had somebody else with you they could ground you, they could
19 reassure you, it could be a light touch, it could be something
20 familiar. Sometimes we use things like a positive affirmation.
21 You might have an affirmative card by your bedside that says
22 it's 2021, I'm in Fredericton, it's okay. You know, just

1 something repetitive.
2 Sometimes it might be a particular picture that is resonant
3 for you, that you can hyperfocus on and helps connect you. It's
4 literally it's what grounding means, so it grounds you in the
5 here and now as against wherever you were sort of heading off
6 to.
7 **Q.** Right.
8 **A.** So those are skills you would normally expect that he
9 would be using.
10 **Q.** And he either had not developed those skills or was
11 not using them to deal with his symptoms at that time?
12 **A.** Correct, sir. Yes.
13 **Q.** Okay. So that visit was January 27th, 2016, and it
14 seems that you see him next on May 9th, 2016. So that's a
15 period obviously of several months.
16 Do you recall what happened between January and May and why
17 he had not attended other appointments?
18 **A.** He didn't come back, he'd gone ... and this is not
19 from my contemporaneous notes, it's probably from some of the
20 other records. So he he'd gone back to Antigonish. He had at
21 some point ... in fact, I believe Dr. Murgatroyd had, at some
22 point, offered if I could follow him up on telephone. He turned

1 that down.
2 Because he wasn't on medications he was also a bit more
3 hesitant about why he needed to be seeing me, you know. So
4 altogether the main reason was that he wasn't even in
5 Fredericton. And by the time I actually saw him he had just
6 come back to Fredericton. He'd returned about three weeks
7 prior.
8 **Q.** Okay. It would appear when you saw him then in May of
9 2016 he wasn't doing so good. You say in your note, which is at
10 page 28: "Today he came in very upset, angry, with lots of
11 paranoid-sounding accusations against his wife and a strong
12 feeling of being victimized and being cheated financially by
13 her."
14 So again, we're back to some of the perhaps over-valued
15 suspicions and paranoia?
16 **A.** Yes, sir.
17 **Q.** Did you have a sense of if that presentation or those
18 emotions kind of waxed and waned with him, fluctuated?
19 **A.** I would say yes it did. And, indeed, when I look back
20 even further at the trajectory of his care, clinical care under
21 Dr. Joshi, equally it had waxed and waned even back then.
22 I think in 2013 or so was when he got discharged actually

1 from care with Dr. Rogers, and at that point he was being
2 reported to have subsided. Dr. Joshi's notes were saying that
3 his symptoms were in remission, his PTSD symptoms. So he did
4 tend to wax and wane, yes.
5 **Q.** Appreciating he was in some geographic flux going back
6 and forth between Nova Scotia and New Brunswick, he seems to
7 have deteriorated between January and May. Would there have
8 been anything that you could see that might have helped to keep
9 him stabilized and in a little better frame of mind during those
10 months?
11 **A.** I guess it was the stability but the challenge was how
12 could we ... how do you deliver that. Stability was the one
13 word that came up again and again. Stability in terms of
14 regular engagement or regularly keeping appointments or even
15 making appointments. Sometimes it was impossible to set an
16 appointment because he said, Oh no, I'll be away this time or
17 I'm not so sure when I'll be back or I'll be back then and then
18 he called. So there was always that. Stability was the main
19 thing that I guess I would say we needed most.
20 **Q.** Right. The sense of paranoia and suspicion that you
21 see on this occasion, is that greater than what you had seen
22 before or can you compare to the way you had seen him before?

DR. ANTHONY NJOKU, Direct Examination

1 **A.** No, I wouldn't say it was that much greater, no. I
2 would just say it was greater.
3 **Q.** "Greater" meaning he was more suspicious and paranoid
4 than he had been before?
5 **A.** No, no, what I mean is I probably have seen him much
6 more suspicious before.
7 **Q.** Oh, I see. Okay. All right. So this wasn't
8 necessarily worse than you had seen him before?
9 **A.** No.
10 **Q.** Okay. You were able to actually prescribe him a
11 medication on this particular occasion, Abilify, two milligrams
12 daily?
13 **A.** Yes.
14 **Q.** What is that drug and why was it prescribed for him?
15 **A.** So Abilify is an antipsychotic and, again, like we
16 were discussing earlier for risperidone, it is just another
17 antipsychotic that we could sometimes prescribe for mood
18 stabilizing. It actually has positive mood stabilizing effects.
19 It can be used to augment an already pre-existing
20 antidepressant. It would help soothe and sedate and calm overly
21 agitated people and it does have specifically antipsychotic
22 properties. So that's why. Much the same as risperidone, it

1 was another option.

2 He'd reported side effects from risperidone. He had

3 reported significant sexual side effects, so again it was an

4 attempt to try and accommodate some of his concerns so we could

5 improve compliance.

6 **Q.** As I understood, the risperidone was previously

7 prescribed in lower doses. So, although it's an antipsychotic,

8 it wasn't strictly being used as an antipsychotic drug. Is that

9 ... do I understand that correctly?

10 **A.** Yes, sir. Yes, that's correct.

11 **Q.** Is that the same with the Ability, that it's ... was

12 it being used as an antipsychotic?

13 **A.** It was being used to manage his agitation, to calm

14 things down and slow him down and not leave him as wound up and

15 as agitated as he was.

16 However, in terms of the dosing, particularly with the

17 Abilify, it's usual to step it up very slowly because sometimes

18 some of the side effects can actually be much more significant

19 in terms of agitation or ... not anxiety, anxiety and

20 restlessness is one of the primary things it could worsen. So

21 usually you have to start very slow, start at the lowest, and

22 then once that's been tolerated you can step it up.

1 **(12:10)**

2 **Q.** You did say in your letter that you thought it might
3 help to soften his suspiciousness and allow him to make more
4 rational decisions. So would the Abilify have helped with his
5 perhaps overvalued suspicions?

6 **A.** It would have, yes.

7 **Q.** Okay.

8 **A.** That was my hope.

9 **Q.** Right. Was he resistant to taking Abilify or were you
10 able to convince him easily to take it?

11 **A.** I was able to convince him, I'm not sure how easily,
12 but the end result was that he did accept it.

13 **Q.** Right.

14 **A.** So as against what previously when he would simply say
15 no.

16 **Q.** Right. Okay. He didn't express any homicidal or
17 suicidal thoughts on this particular day and I assume you would
18 have noted those had they been present?

19 **A.** Yes, he didn't express any.

20 **Q.** Okay. So at this stage, he's on track to go to the
21 residential treatment program at Ste. Anne's?

22 **A.** Yes, sir.

DR. ANTHONY NJOKU, **Direct Examination**

1 **Q.** Okay. You did say at the very end of the paragraph:
2 "Efforts have been doubled to speed up processing of his
3 admission to Ste. Anne's, but in the meantime he may benefit
4 from a clinical case worker who could help him set up some
5 structures and routines and perhaps work with him towards
6 applying his relaxation strategies."
7 So, again, the suggestion that someone to help him I guess
8 in the community, a clinical care worker, would have benefited
9 him?
10 **A.** Yes, but it was again subject to his being in any one
11 place sufficiently enough. And even now he was even more sort
12 of ... he was less stable even now, because I think his home was
13 just being sold and here he was actually planning to completely
14 relocate back to Antigonish. So he was always limited by the
15 fact that we couldn't get him in any place long enough.
16 **Q.** Right. You were aware of him having a case manager, I
17 think, from Veterans Affairs at that time?
18 **A.** Yes.
19 **Q.** Were you aware of anyone else, though? Like a
20 clinical care manager or someone of that variety to help him?
21 **A.** No, I didn't know of anyone assigned to him at that
22 point, no.

DR. ANTHONY NJOKU, Direct Examination

1 **Q.** Okay. That was ... May 9th, 2016 was the last time
2 that you had seen him prior to him going to Ste. Anne's?
3 **A.** Yes, it was.
4 **Q.** At that point, did you know precisely when he would be
5 going to Montreal?
6 **A.** No, but I would have subsequently have been told when
7 the date and the time was available. But at that point I didn't
8 know exactly.
9 **Q.** Okay. And I appreciate it says that efforts were
10 being made to get him in or to process his admission. Go ahead.
11 **A.** No, I was just going to add, at that point we had
12 already gone through a few cycles of Ste. Anne's offering a
13 date, he, you know, initially being open to it and then again
14 later turning it down. So I think this last time somebody had
15 contacted them and they had accepted (inaudible - audio) and
16 find him something ASAP.
17 **Q.** So your recollection was that he had actually had, I
18 guess you would say, a bed available at Ste. Anne's previously
19 and had turned it down?
20 **A.** Yes, sir.
21 **Q.** Do you recall talking to him about that yourself?
22 **A.** Not directly, no. No.

1 **Q.** That would have been Dr. Murgatroyd perhaps or other
2 people at the ...
3 **A.** It would ... it would ... yes, it would have been Dr.
4 Murgatroyd, yes.
5 **Q.** Okay. After he went to Ste. Anne's did you have an
6 expectation that you would be receiving information back from
7 the hospital? Is that typically what happens?
8 **A.** Typically we would receive information back from the
9 hospital, yes.
10 **Q.** Appreciating his living situation was indeterminate,
11 had he come back to New Brunswick after Ste. Anne's and stayed
12 there, would he have continued to be under your care?
13 **A.** He certainly would have, yes.
14 **Q.** Okay. You didn't, in fact, though treat him again
15 after he returned from Ste. Anne's?
16 **A.** No.
17 **Q.** Okay.
18 **A.** No. He did periodically get discussed, so there were
19 ongoing discussions about him which I was aware of. Dr.
20 Murgatroyd was still in contact with him which I was aware of.
21 His discharge from Ste. Anne's, he was discharged on
22 medications, which again I was aware of. So I was updated

1 periodically, particularly when the discussions came on, because
2 if I recall, Dr. Murgatroyd remained in contact far longer
3 actually than the usual because for so long, he couldn't get
4 reconnected to anybody else, so he was left holding and trying
5 to keep some sort of contact with him going.
6 **Q.** Was his case discussed again at the IDT meetings or
7 would that ... was it more ...
8 **A.** Yeah, it was. It was discussed a few times. In fact,
9 I think up to the point when there was a consensus that it was
10 okay for Dr. Murgatroyd to close his care having kept him open
11 for that period and having connected or done as much as he could
12 to connect him onto subsequent care.
13 **Q.** Okay. He apparently left Ste. Anne's early. Did you
14 receive that information?
15 **A.** We received it. Again, I don't recall exactly because
16 I wasn't directly looking after his care, but I do recall. My
17 understanding then was it wasn't too ... he had done a
18 substantial portion of the treatment was my understanding. Some
19 of the reasoning was somewhat legitimate. I think it was around
20 his daughter, if I'm not mistaken, something about having to see
21 her back or her return back to school. And I'm being vague here
22 because I don't recall exactly but I think that's what drove

1 that. And our take on it at the time, again, was probably,
2 Okay, we got a good deal out of this, first bite, and we could
3 always ... something could always be set up again if needed.
4 And besides, the idea was always for him to carry on in the
5 community.
6 **Q.** Right.
7 **A.** A lot of the feedback, if I remember, from Ste. Anne's
8 was positive.
9 **Q.** Okay. So, and appreciating you didn't treat him
10 again, but going forward, did you have a sense of what he
11 would've needed to maintain stability and good mental health?
12 **A.** Stability. Again, stability and then engagement.
13 Engagement with all the necessary services, engagement with
14 psychiatry. I always thought, and still thought, he shouldn't
15 have anything again to do with the marijuana. I'd hoped, being
16 that he'd had a spell of being off it in there, he wouldn't be.
17 Those would have been the things. And our hope was that once he
18 got settled with therapy, he would be in a better position to
19 actively do the trauma processing work, because so long as you
20 don't do the trauma processing work, you really do always remain
21 vulnerable to a lot of the symptoms coming back if they are
22 significantly retriggered.

1 **Q.** Okay. So the trauma processing work with a therapist
2 or a psychologist would've been important for him to maintain
3 good mental health?
4 **A.** Yes, sir.
5 **Q.** All right. Just one moment. Doctor, thank you.
6 Those are the questions that I have. Some of the other counsel
7 may have questions.
8 **A.** Thank you.
9 **THE COURT:** All right, thank you. Ms. Ward?
10
11 **CROSS-EXAMINATION BY MS. WARD**
12 **(12:19)**
13 **MS. WARD:** Good afternoon, Dr. Njoku. My name is Lori Ward
14 and I represent the Government of Canada. So that means I
15 represent ...
16 **A.** Good afternoon.
17 **Q.** ... entities like Veterans Affairs and Canadian Armed
18 Forces among others. I just have a few questions.
19 You talked a bit about Dr. Wendy Rogers' clinical notes and
20 the fact that the package that you received, in terms of Lionel
21 Desmond's records from the OTSSC, included Dr. Joshi's notes but
22 only possibly some summaries of Dr. Rogers? That's correct?

1 **A.** That's correct, yes.
2 **Q.** Okay. But you were aware that she had treated him for
3 over two-and-a-half years and you put that in your own notes.
4 Correct?
5 **(12:20)**
6 **A.** Yes, correct.
7 **Q.** You mentioned that in the triage process, when the
8 interdisciplinary team meets and discusses new cases and who
9 should deal with them, you sometimes take into account
10 considerations like francophones or other things like that. I
11 wonder, does gender ever enter the picture in terms of treating
12 physicians or psychologists for a patient? Are there certain
13 times when a patient prefers one gender clinician over another?
14 **A.** Yes, correct.
15 **Q.** And are there times when a patient will open up or
16 engage more with a certain gender?
17 **A.** Yes, but that's a bit more difficult for us to tell or
18 to preempt. So the gender issue would probably have been raised
19 by the patient himself, if that's a preference, or may sometimes
20 have been indicated in the previous notes that this patient is
21 more inclined to a particular gender over the other.
22 **Q.** Thank you. It became apparent when Dr. Murgatroyd was

1 here yesterday that in Lionel Desmond's treatment by the OSI
2 clinic in New Brunswick, it was the first time that he had
3 raised issues of potential head injuries. And you mentioned
4 today chronic back pain and a fall that he said that he had had.
5 That's the first time that this was raised and appears on the
6 record and I'm wondering what, if anything, did he ask you to do
7 or what appeared from the record in front of you in terms of
8 that fall that he told you about?
9 **A.** Actually, the opposite. So looking through, and I
10 think it's Dr. Joshi's initial assessment report. I wish I had
11 the page. So looking through Dr. Joshi's original initial
12 assessment. In fact, it was probably the exact opposite that
13 was stated. So there was stated no head injuries, no trauma to
14 the head, or something like that. And perhaps I'm paraphrasing,
15 but he did point that out. So from the notes, we didn't really
16 get anything. This was more his self-report from the initial
17 assessment I did where he ... again, as part of what we would
18 cover - medical history, past medical history. He said he'd had
19 that fall and then he said there was a roll, an LAV roll, a
20 light-armoured vehicle in which he was travelling that rolled
21 over.
22 **Q.** And so to your knowledge had he ever been treated for

1 chronic pain?

2 **A.** He was. Indeed, in fact, when the marijuana ... when

3 he was prescribed marijuana was supposed to be for chronic pain.

4 **Q.** I see. Thank you, Dr. Njoku, those are my questions.

5 **THE COURT:** Thank you, Ms. Ward.

6 **A.** Thank you.

7 **Q.** Mr. Anderson?

8 **MR. ANDERSON:** I have no questions, Your Honour.

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

10 **MR. MACDONALD:** Thank you, Your Honour. I have a question.

11 **THE COURT:** Certainly.

12

13 **CROSS-EXAMINATION BY MR. MACDONALD**

14 **(12:24)**

15 **MR. MACDONALD:** Thank you.

16 Good afternoon, Dr. Njoku. I'm Tom Macdonald and I am the

17 lawyer for the Borden family, so Cpl. Desmond's late wife, her

18 parents, and also her brother and I share corepresentation for

19 Aaliyah Desmond with Ms. Miller who may have questions for you

20 later.

21 Doctor, I just wanted to ask you about the referral letter

22 in December of 2015. That would be the letter where Dr.

1 Murgatroyd signed it. Your name appeared at the bottom. If you
2 want to turn to it, you can, but it's not a hard question. It's
3 Exhibit 244. It's pages 95 to 97 and it's the referral letter
4 to VAC asking that Cpl. Desmond be sent to Ste. Anne's. You're
5 familiar with that letter?
6 **A.** Yes, I am sir, yes.
7 **Q.** Yes. There's a number of factors listed there by Dr.
8 Murgatroyd on page 97 and we went through, he and I yesterday,
9 this letter a little bit. By the way, did you happen to watch
10 his evidence yesterday, Doctor?
11 **A.** No, I didn't, unfortunately.
12 **Q.** No. Sure, that's fine. So one of the things that
13 came out of that discussion we had, Dr. Murgatroyd and I
14 yesterday, was that there was not a specific reference in the
15 reference letter to spousal issues or marital issues or anger
16 with the person being referred, Cpl. Desmond, towards a spouse,
17 and whether it would be helpful going forward if those types of
18 letters, the writers would include a separate reference to that,
19 whether it's a separate sentence or two or three, or a paragraph
20 or something, so that subsequent readers can see that it is,
21 that issue is flagged, especially where we have a person like
22 Cpl. Desmond who was a combat veteran, who had personal weapons

1 at home, who had severe, diagnosed by doctors, PTSD, so that the
2 next reader sees that that is an issue and that person has
3 issues perhaps with a spouse.
4 Do you think that would be helpful going forward if that
5 was flagged in letters like that?
6 **A.** I would certainly think so, yes, sir.
7 **Q.** Okay.
8 **A.** In addition, though, normally with a referral pack
9 like this would go some of the other initial assessments,
10 perhaps some of which I would have done. So I'm not quite sure
11 if that didn't happen here, but you're right, it absolutely
12 should have been highlighted.
13 **Q.** Thank you, Dr. Njoku, that's my question. And on
14 behalf of the Borden family, thank you for your comments earlier
15 this morning in response to Mr. Russell about Ms. Desmond, Cpl.
16 Desmond's wife.
17 **A.** Thank you, sir.
18 **Q.** Thank you very much, Doctor.
19 **A.** Thank you. Thanks.
20 **THE COURT:** Thank you, Mr. Macdonald.
21 **MR. MACDONALD:** Thank you, Your Honour.
22 **THE COURT:** Ms. Miller?

1 **CROSS-EXAMINATION BY MS. MILLER**
2 **(12:27)**
3 **MS. MILLER:** Good afternoon, Dr. Njoku. My name is Tara
4 Miller. I'm counsel representing the late Brenda Desmond, so
5 Cpl. Desmond's mother, and as well, sharing representation with
6 my friend who just spoke, Mr. Macdonald, with respect to Aaliyah
7 Desmond, Cpl. Desmond's daughter. So I just have ...
8 **A.** Good afternoon.
9 **Q.** Good afternoon ... a few questions for you. I want to
10 talk to you about the clinical care manager, and you may have
11 given an answer to the question I'm going to ask you, but I just
12 wanted to take you through different times from your notes when
13 you identified that that would be of help to Lionel, given the
14 severity of his PTSD and all the attendant symptoms.
15 So your evidence was on August the 31st, that was the first
16 time you met with Cpl. Desmond, you identified that a clinical
17 care manager would be of assistance. Correct?
18 **A.** Correct.
19 **Q.** Okay. And then on December 3rd, 2015, your notes
20 again reflect that you're going to ... you think it's necessary
21 to set him up with a clinical case manager. And then the last
22 time we see you reference it is May 9th, 2016, again that the

1 clinical care manager is needed.
2 What steps would've been taken by you or anyone in your
3 clinic to implement or to action that reference to the clinical
4 case manager from August to May?
5 **A.** So at each point, it would have involved us connecting
6 to his case manager and from the initial point, at the very
7 least, we would have had to connect with her, run by her why we
8 were making that suggestion and recommending that they arrange
9 for a clinical care manager. Subsequently, it would have been
10 kind of like a follow-up. He still needs this. What's holding
11 it? You know, we need to do this for him.
12 **Q.** Okay. So if I understand your evidence, you're saying
13 that on August the 31st, when you first identified the clinical
14 care manager, you would then have involved his Veterans Affairs
15 case manager with a recommendation that that be implemented?
16 **A.** Yes. So when I assessed him and recommended that he
17 would need a clinical care manager, I think I did point out
18 there, I would ... I went back to the IDT again just to get a
19 consensus around that. And at that point, Dr. Murgatroyd would
20 have been also part of that discussion.
21 **(12:30)**
22 When it came to most of the ... I hate to say, but most of

1 the legwork in terms of follow-up and ... you know, it would
2 have been more Dr. Murgatroyd who would follow-up on those
3 pieces. But I think, as a team, and even between both of us, we
4 had always agreed that this was a treatment plan for that.
5 **Q.** Okay. So from August 31st, after you meet with Cpl.
6 Desmond and then you have your IDT team meeting, your
7 understanding is that it would've been Dr. Murgatroyd who
8 would've needed to action that referral for the clinical case
9 manager at that point?
10 **A.** Yes.
11 **Q.** Okay. And is it your understanding that he did
12 attempt to action the clinical case manager by requesting that
13 through Veterans Affairs and nothing came of it?
14 **A.** It's my understanding, but I would stop short of
15 "nothing came of it" because I don't actually recall exactly
16 what the follow-through conversations were.
17 **Q.** Okay.
18 **A.** So I don't recall because, of course, I would have
19 been, Oh, he still needs a clinical care manager. And I don't
20 know what ... I can't recall readily what the feedback was. Oh,
21 We can't have one or, We don't have anybody, or, We can't find
22 him, or, He wants to ... we are waiting till he goes back or

1 till he settles. All of those may have been in the mix but I
2 don't recall exactly, I'm sorry.
3 **Q.** That's okay. And, Doctor, did you ever have occasion
4 to have any communication with Cpl. Desmond's case manager from
5 Veterans Affairs during the course of his OSI New Brunswick file
6 carriage?
7 **A.** Actually, one occasion, which was after.
8 **Q.** Yeah, after ...
9 **A.** So she came. Yes, after the fatality, after his
10 death, unfortunately.
11 **Q.** Tragedy. Okay.
12 **A.** So I think she came to the OSI clinic for a different
13 meeting and it turned out that she was the case manager and,
14 yes, so there was a bit of feedback session, debriefing,
15 support, and that.
16 **Q.** Okay.
17 **A.** Yes.
18 **Q.** So prior to that, you had no opportunity, you did not
19 meet or speak with or communicate with Cpl. Desmond's case
20 manager, whoever that may have been.
21 **A.** No, I don't recall, no.
22 **Q.** And from your perspective, after meeting with him in

DR. ANTHONY NJOKU, Cross-Examination by Ms. Miller

1 August of 2015 - Cpl. Desmond - and having the IDT meeting, you
2 believed that that referral for the clinical care manager
3 should've been implemented through the request system with VAC.
4 **A.** Yes.
5 **Q.** Okay. So on December 3rd when you saw Cpl. Desmond
6 again and you note in your notes, you know, again this reference
7 to setting him up with a clinical case manager, what did you do
8 to address what the status was of what you had suggested needed
9 to be done in August? So this is several months later.
10 **A.** The biggest challenge was about him being in any one
11 place at any time.
12 **Q.** Yes.
13 **A.** So each time I ... when I even couldn't get to see him
14 consistently, I was in a really difficult position to be asking
15 for something to be put in place if he wasn't there to avail
16 himself of it.
17 Even further, he, at different times, kept saying he's back
18 at Antigonish and he's not coming back. Even before he sold his
19 home. So that bar kept shifting backwards and forwards.
20 Again, if I recall, earlier in 2015, after I had seen him,
21 it sounded like he was moving back home, and had moved back
22 home, and Dr. Murgatroyd was involved a little earlier, but

1 having to, trying to transfer his care only when it turned out
2 he hadn't really left because it was taking longer to move, to
3 sell his home. Only then did it come out that he was still
4 being ... staying with us and then he was able to follow through
5 with me.
6 **Q.** Okay.
7 **A.** So I think that was the, from my recall, that was
8 always the biggest problem, even in putting in place whatever we
9 had wanted to.
10 **Q.** Fair enough. So your evidence, as I understand, is
11 that the reason that you understand a clinical care manager was
12 never put into place was because of the transient nature of Cpl.
13 Desmond moving back and forth from Nova Scotia to New Brunswick?
14 And is it ...
15 **A.** Yes.
16 **Q.** Is it your understanding, though, that that request
17 actually went to Veterans Affairs and that was the reason why
18 they weren't able to implement it?
19 **A.** It's my understanding that the request was put to
20 Veterans Affairs for sure. I can't recall. I would've had
21 conversations with Dr. Murgatroyd about some of the challenges,
22 including the fact that he wasn't at any given place for any

1 given time. I don't know for sure that I heard directly from
2 Veterans Affairs but that was their reason.
3 **Q.** Okay. So we reviewed yesterday with Dr. Murgatroyd
4 his notes and it appears that there was not a case manager for
5 Cpl. Desmond until the end of November. And the reason that a
6 case ... Well, Dr. Murgatroyd had to make inquiries to identify
7 who the case manager actually was. So by certainly then, by
8 December 3rd, 2015, from your notes, that's again the second
9 time you flagged the clinical care manager. So at that point,
10 there is a case manager we know, in place, from the records, and
11 you would've expected if ... that that again ... would your
12 expectation have been that Dr. Murgatroyd would've actioned the
13 implementation again with a request through the case manager at
14 that point?
15 **A.** I would have thought so, yes. And I would like to
16 imagine that's actually why we were following through with
17 getting them to identify a specific case manager for him.
18 **Q.** Okay, thank you.
19 We have as Exhibit 244 the complete records from the OSI
20 New Brunswick clinic. I want to just ask you a quick question.
21 If I can get you to turn to page 36. 36 to page 41. Do you
22 have those, Dr. Njoku?

1 **A.** I do, yes.
2 **Q.** Okay. Do you recognize the handwriting here? These
3 are handwritten notes.
4 **A.** I do. Those are my handwritten notes.
5 **Q.** Okay. I thought they might be. And if we look at the
6 top of page 36, it says, "Desmond, Lionel. 31/8." Are these
7 the notes that you would've taken during your initial meeting
8 with Cpl. Desmond on August 31st, 2015?
9 **A.** Yes, they would be.
10 **Q.** Okay. And I'm not going to get you to take us through
11 them verbatim, although perhaps, you know, through your counsel,
12 we could get a transcript of these notes or an actual typed
13 record of these notes. But what I would like you to address for
14 us is at page 37, halfway down the page, it looks to me, from
15 what I can decipher, Doctor, that these are notes that may
16 relate to details around Cpl. Desmond's physical conditions. Is
17 that a fair assessment?
18 **A.** It is correct, yes.
19 **Q.** Okay. Could you just read those for us?
20 **A.** So these notes would essentially be the same as the
21 typed initial report I had done. What I'd written here is: "A
22 bad back. Fall. Ten-feet fall onto his back. Thought it was a

1 viper pit. Then there was an LAV rollover with soft-tissue
2 injury to his neck. He was attending a jump course training.
3 Hit the ground from the jump."
4 **Q.** So these are three, as I read these, these are three
5 different incidents. The bad back from a fall, ten feet into
6 ... something about a viper pit? Is that the first one?
7 **A.** Yeah, yeah.
8 **Q.** Okay. The second is a LAV rollover with a soft-tissue
9 injury to neck. And then the third one is the jump training and
10 he hits the ground hard?
11 **A.** Yes, but it's likely the jump training is the same as
12 the fall - the first one.
13 **Q.** Okay. That's your understanding, your recall?
14 **A.** Yes.
15 **Q.** Okay. And then what's the next ... can you finish,
16 just take us through the next few notes?
17 **A.** The next ones are actually somewhat more different.
18 So that's more paranoid thoughts, yeah.
19 **Q.** Okay, thank you.
20 **A.** Then I think he received the marijuana for the trauma
21 is the line under that.
22 **(12:40)**

DR. ANTHONY NJOKU, **Cross-Examination by Ms. Miller**

1 **Q.** That is where the reference to the medical marijuana
2 prescription for the trauma for the physical injuries?
3 **A.** Yes.
4 **Q.** Okay.
5 **A.** Yes.
6 **Q.** Okay. I want to talk about next the expectation of
7 time that would lapse between when a patient is referred to Ste.
8 Anne's. And if I understood your evidence, I think you said it
9 would generally ... it was luck of the draw in terms of when a
10 client or patient could expect to get into Ste. Anne's from
11 referral but also that you thought it would generally be about
12 three weeks from when it was agreed that this is going to
13 happen?
14 **A.** It could be anything from three weeks. It could be
15 much longer, yeah.
16 **Q.** And certainly, in this case, we know from the records
17 and Dr. Murgatroyd's evidence yesterday, the recommendation, the
18 referral, if I will, to Ste. Anne's went in December 15th, 2015.
19 Then in your chart note of January 27th, so this is the second
20 visit you have with Cpl. Desmond after Christmas, you note that
21 he was expecting admission within four weeks? Okay. And do you
22 know where he would have ...

1 **A.** Mm-hmm.
2 **Q.** ... received that information that he was expecting
3 admission within four weeks?
4 **A.** He would have received it either from his case
5 manager, his VAC case manager, or usually the residential
6 program would contact him, they would do their own initial
7 screening, their walk-through, what his expectations are, sort
8 of talk through what the treatment plan might be or might look
9 like. So during that process ... usually that might take one or
10 two such contacts and it would be during that process they might
11 be able to give him some dates that he could work with, some
12 potential admission dates.
13 **Q.** Okay, thank you. And we know, of course, from the
14 records, that he ultimately was not admitted until May the 30th.
15 Do you have any understanding as to why there was such a delay
16 from January 27th when Cpl. Desmond expressed to you that he
17 would be going in four weeks?
18 **A.** If I recall ... I don't think I can ... I didn't mark
19 the page, but I think this was where he turned it down. He
20 changed his mind. So he was offered that date and,
21 subsequently, he changed his mind. And I think he'd also been
22 back at Antigonish at that time. And that really was ... it was

1 down to him really, not from Ste. Anne's.
2 **Q.** So you understand that he turned down an earlier time
3 at Ste. Anne's?
4 **A.** Yes.
5 **Q.** Okay. Do you have any recollection, Doctor, that he
6 was told he would need to be paying for his travel to Ste.
7 Anne's and that was a significant concern for him in terms of
8 funding the ability to get there and that that was the reason
9 why he may have hesitated in the attendance at Ste. Anne's after
10 Christmas of 2015?
11 **A.** I don't recall that, no. What I do recall is that who
12 would pay for the travel was a concern for him.
13 **Q.** Yes.
14 **A.** My understanding has always been that VAC paid. What
15 I'm not sure about is whether they request ... whether they
16 require him to pay ahead and then they reimburse him but my
17 understand- ... usually, that hasn't been an issue, but people
18 periodically would have concerns or anxieties about who is going
19 to pay for what and how will I get there?
20 **Q.** Okay.
21 **A.** So I don't recall it being a request or a demand that
22 he pays and then he couldn't.

1 **Q.** Okay. But do you have a recollection that there was
2 some concern with Cpl. Desmond - and if you don't, that's fine -
3 but do you have a recollection there was some concern with Cpl.
4 Desmond about how he was going to make financial arrangements to
5 facilitate getting to Ste. Anne's?
6 **A.** I think I read somewhere here. I don't recall it off
7 the top of my head, but I read somewhere within his notes that
8 there was a reassurance given from VAC that they were prepared
9 to pay ... cover all his costs.
10 **Q.** Okay.
11 **A.** So I can only ... I don't know, I can only read from
12 that that that was an issue and then they had to reassure him
13 that it wasn't the case. I wish I knew. I could pull it off
14 right away but ...
15 **Q.** Okay. Well, I'll help orient you, I think. If I can
16 take you to page 56 of Exhibit 244. Are you there, Doctor?
17 **A.** Okay. Yes, yeah.
18 **Q.** So we have ... this is a March 9th, 2016. It is from
19 it looks like Dr. Murgatroyd. And the focus says: "Mr. Desmond
20 returned writer's call. Phone chat." They talk about a number
21 of things. Midway ... at this point he says:
22 He has yet to hear back from Ste. Anne's

1 Hospital about his admission there. He did
2 speak with his case manager about the
3 logistics of getting to and from the
4 airport. His case manager informed him that
5 typically veterans are asked to pay their
6 travel fees and then reimbursed. Mr.
7 Desmond expressed some concern about this
8 given his current financial situation. Ms.
9 Doucette, his case manager, said she would
10 follow up with her supervisors at VAC to see
11 if there's a way to help him pay for the
12 costs. Mr. Desmond says he continues to
13 stay sober. He's been drinking a lot of tea
14 and water instead of self-medicating ... et
15 cetera, et cetera.
16 So that is the reference, I think, that you might have been
17 talking about, about being ... veterans having to pay for their
18 travel costs?
19 **A.** Mm-hmm.
20 **Q.** Okay. And then as we go through the notes we
21 certainly ... the notes speak for themselves. But they talk
22 about, you know, significant financial stresses through this

1 period of time and the impact on Cpl. Desmond.
2 And then we get to ... I'm going to take you to page 51,
3 Doctor.
4 **A.** Yes.
5 **Q.** And we see a note halfway down the page from May the
6 3rd, 2016. And it is a note made by Dr. Murgatroyd. It says:
7 "Writer left voicemail with case manager. Writer left a message
8 on Mr. Desmond's case manager's voicemail expressing concerns
9 about Mr. Desmond, who is expressing significant financial
10 stress. Writer wonders if VAC might be able to help out."
11 Do you remember having discussions in your
12 interdisciplinary team meetings about the financial stress and
13 the implications on Cpl. Desmond through this period of time?
14 **A.** I do recall discussions certainly with Dr. Murgatroyd,
15 yes, and as well, with Desmond. So he'd raise ... periodically,
16 he would raise the issues about his sorry finances and we had
17 always been looking to see what more could be done and what
18 extra financial supports we had available for him.
19 **Q.** Okay. The last note I'm going to get you to look at
20 on this topic of the funding for travel is at page 49 and this
21 is the last note ... well, the second-last note on this page.
22 And it's dated May 20th, 2016. And it says, "Phone contact with

1 case manager." Again, this is from Dr. Murgatroyd. It says:
2 Writer received a call from Mr. Desmond's
3 case manager, Marie-Paule Doucette, who
4 expressed concerns about Mr. Desmond. She
5 had met with him the previous day to go over
6 logistics of his trip to Montreal. She
7 indicated that VAC was able to purchase his
8 plane ticket ahead of time because of his
9 financial situation.
10 So I take from this that, you know, it wasn't until May
11 19th that Mr. Desmond received some peace of mind about the
12 funding that he had raised to travel to Ste. Anne's. Would you
13 agree with that from reading this note in your clinic file?
14 Oh, I can't hear you. Sorry, Doctor. We can't hear you at
15 this end.
16 **A.** Sorry, I seemed to have muted myself.
17 **THE COURT:** It's all right.
18 **A.** Sorry.
19 **MS. MILLER:** So ...
20 **A.** So ... so yes, it does indicate here that this was the
21 first ... this was at the point at which he was sure of what the
22 financial arrangements were going to look like, yes.

1 **Q.** Yeah, and the financial expenditure was more than just
2 getting to and from the airport. It actually involved buying a
3 plane ticket to get to Montreal to attend the program. Correct?
4 **A.** Again, in fairness, this isn't something I would have
5 known a lot about and again, if I look at the timeframe during a
6 lot of that time I wasn't directly ... I wasn't as regularly
7 seeing him. So I wasn't always in ... aware of all the issues.
8 **(12:50)**
9 When it comes to finances and the funding, I had the
10 general picture he was struggling. There's no question about
11 that and we were trying to push for that. But the specifics,
12 particularly with VAC and back to Dr. Murgatroyd, I may not have
13 been directly as involved in.
14 **Q.** Okay. Thank you. The last question I want to ask you
15 about, Doctor, is dissociation. Just maybe some general
16 concepts. You were asked by my friend, Mr. Murray, how long
17 Cpl. Desmond's periods of dissociation could last when he was in
18 sessions with you and I think you said they could be several
19 minutes. But generally speaking, you know, how long can periods
20 of dissociation last with individuals who are affected by this?
21 **A.** It could be any length of time, it could be
22 interminable. So for instance, a dissociative experience, the

1 extreme form of it is when you hear or read about people who
2 turn up in a separate ... another town who can't remember their
3 name. They don't know where they're from. They don't know how
4 they got there.
5 **Q.** Right.
6 **A.** Some may recover eventually. Some, they just ...
7 nobody tracks. So it's impossible for me to say how long.
8 **Q.** Right.
9 **A.** You know, it's almost when you say, How long is a
10 piece of string? It could be any length of time.
11 **Q.** Right.
12 **A.** And even worse, he wouldn't be able to give us much
13 detail himself because when he's dissociated he's not aware.
14 **Q.** Right.
15 **A.** So it's difficult for me to track that by getting a
16 history from him unless somebody was with him.
17 **Q.** Yes.
18 **A.** Unless he is able to tell me, I don't know, you know,
19 I was driving to Moncton and then I found myself in Halifax.
20 **Q.** Right.
21 **A.** So I may be able to then assess that.
22 **Q.** And I think you answered my next question. You said

1 there are some cases where people end up in the next town. They
2 have no idea how they got there. So I was going to ask you,
3 what can people actually accomplish when they're dissociated?
4 Can they drive a car, for example?
5 **A.** They can, yes.
6 **Q.** Okay. And what types of things would trigger a
7 dissociation experience generally, Doctor?
8 **A.** Significant stress.
9 **Q.** Okay. And those things could include being in a motor
10 vehicle accident?
11 **A.** Yeah. In his case it would be significant trauma
12 stress. So the stress of recalling or reliving. So in PTSD
13 particularly, dissociative state is an extreme form, it's more
14 or less what we call flashbacks. So when people talk about
15 flashbacks for that minute they are back in time, they are back
16 in place, and that could last any length of time.
17 **Q.** So are you saying that it would have to be trauma
18 stress like something that would be triggering trauma that would
19 trigger the dissociative state?
20 **A.** For PTSD.
21 **Q.** For PTSD.
22 **A.** Yes.

1 **Q.** Okay.
2 **A.** Yeah, usually. But overall it's any significant
3 stress would cause that for (inaudible - audio).
4 **Q.** Okay. But for those people with PTSD you said usually
5 it's the trauma stress but could it be other life events,
6 significant stressful life events that could trigger a
7 dissociative state with somebody with PTSD?
8 **A.** It's hard for me to say because, again, if ... from my
9 understanding with PTSD the most significant stress, comparative
10 to anything else going on in their life, usually from the people
11 I see. So the trauma stress is usually associated, kind of
12 everything else pales into insignificance relatively.
13 **MS. MILLER:** Thank you, Doctor, those are my questions.
14 appreciate your time and your care of Cpl. Desmond when he was
15 at your clinic. Thank you.
16 **A.** Thank you.
17 **THE COURT:** We're just on pause for a minute, Doctor, so
18 we can just check on our recording here.
19 Mr. Rodgers, I know that you're ... do you have a few
20 questions, do you?
21 **MR. RODGERS:** I do, yes, Your Honour. Yes.
22 **THE COURT:** Well, we're going to wait because our

1 recording is down just at the moment and we're going to see if
2 we can just recycle a bit of back-up here.
3 Dr. Njoku and Mr. Browne, the recording system in the court
4 at the present time is down and this proceeding has to be a
5 recording proceeding. Mr. Rodgers has some questions for you
6 and I don't know if Mr. Hayne has any questions. Not likely.
7 But we do need to try and finish off with Mr. Rodgers this
8 afternoon and I'm going to suggest that we take a brief
9 adjournment to see if we can re-establish that so we can finish
10 everything this afternoon.
11 **MR. BROWN:** Thank you, Your Honour, that would be fine.
12 **THE COURT:** All right. Thank you.
13 **A.** Thank you, Your Honour.
14 **THE COURT:** We will disconnect from your gentlemen at
15 the present time and if you standby closely we'll get back to
16 you as soon as we can. Thank you.
17 **COURT RECESSED (12:45 hrs.)**
18 **COURT RESUMED (13:05 hrs.)**
19 **THE COURT:** Dr. Njoku, Mr. Browne, can you hear us all
20 right?
21 **A.** Yes, Your Honour.
22 **MR. BROWNE:** Yes, Your Honour.

1 **THE COURT:** All right. Fine. So court's reconvened.
2 Thank you. Mr. Rodgers has a few ... sorry for the informality.
3 Mr. Rodgers has a few questions for the doctor. Thank you. Mr.
4 Rodgers?
5 **MR. RODGERS:** Thank you, Your Honour.
6
7 **CROSS-EXAMINATION BY MR. RODGERS**
8
9 **MR. RODGERS:** Dr. Njoku, I'm Adam Rodgers and I represent
10 the personal representative of Cpl. Lionel Desmond and so I have
11 some questions. First of all, good afternoon.
12 **A.** Good afternoon, sir. Thank you.
13 **Q.** So what I'd like to go through with you, Doctor, is
14 some thoughts and your experience and knowledge about
15 dissociative experiences and episodes. Because of course it's
16 referenced in your notes but it's also certainly in the
17 literature on PTSD as a ... well, as a subset or subtype of
18 PTSD.
19 So like I say, you've noted throughout your testimony and
20 in your notes this morning that Cpl. Desmond did display some
21 dissociative episodes with you. It's my understanding, Doctor,
22 and I invite you to correct or elaborate that PTSD is noted in

1 the DSM-V to have that subtype of dissociative ... a
2 dissociative subtype of PTSD. And it seems like something that
3 can develop in episodes of significant trauma such as armed
4 combat. It's also referenced in childhood sexual trauma and in
5 refugee situations. So I was wondering if perhaps you had
6 experience in that. You noted earlier that you had dealt with
7 refugee situations when you were in the UK. Is this something
8 you've seen in other circumstances as well?
9 **A.** I would say yes, yes. I have.
10 **Q.** It seems that it's a condition that can develop when
11 an individual is in a traumatic situation from which they can't
12 physically escape and so they, in effect, mentally escape from
13 it in a dissociative manner. Either they escape themselves
14 personally or they escape their situation. In their minds at
15 least. Is that how you would describe it? Or perhaps how would
16 you describe it?
17 **A.** I would probably describe it somewhat differently. So
18 I would describe it differently as it pertains directly to PTSD.
19 **Q.** Yes.
20 **A.** So dissociative episodes with PTSD would be more of an
21 extreme reliving experience. So in that sense they are not
22 necessarily escaping. In that sense they are being overwhelmed

1 by the intrusive imagery or intrusive ... almost the vivid image
2 or vivid recall of the trauma event. So that's somewhat
3 different from how people could be dissociative in terms of just
4 regular stress.
5 So if I'm encountering severe stress yes, my mind could
6 shut down as a way of trying to cope with an overwhelming
7 stress. But it's a bit different with PTSD because with PTSD
8 it's actually the stress itself is part of the experience. It's
9 part of the reliving.
10 **(13:10)**
11 **Q.** So how, then, might that manifest itself in a
12 situation with someone who has PTSD?
13 **A.** He would be acting out the trauma. He would be acting
14 in response to the trauma. He would be located ... at least his
15 conscious awareness would be located in the place of the
16 original trauma rather than here. So he could be looking at you
17 but responding to you as his maybe staff sergeant or the Taliban
18 out there.
19 **Q.** Yeah, so the person is present here in Canada in a
20 peaceful situation but in their mind and in their own reality
21 are back in Afghanistan in a combat situation.
22 **A.** That would be the case, yes. Which almost speaks to

1 why we use grounding as a basic tool because the idea of
2 grounding is to relocate you back in the present.
3 **Q.** So the ground- ...
4 **A.** In the here-and-now.
5 **Q.** So a grounding tool would then reorient the person,
6 Listen, this is 2021, this is where you are, look around you,
7 smell this, this is a familiar situation. You know, then ground
8 them in that manner.
9 **A.** Yes, sir.
10 **Q.** Okay.
11 **A.** Yes, sir, that's right.
12 **Q.** And now I see that you've identified that but I also
13 understand that the treatment through yourself and Dr.
14 Murgatroyd didn't develop to the state yet where you were
15 actively treating him in a thorough manner if I can put it that
16 way. But you hadn't gotten to the point where you were treating
17 the dissociative episodes as a specific condition of Cpl.
18 Desmond's presentation.
19 **A.** The specific treatment of the dissociative episodes
20 would be to process the trauma event itself. So in the course
21 of treating trauma you will eventually relieve them of the
22 dissociations which is an aspect of their trauma. In treating,

1 though, it's a staged approach. So we work with him adequately
2 for the first stage, the primary stage, which was basically
3 stabilization.
4 **Q.** Yes.
5 **A.** Slow things down, calm things, get you into regular
6 routines, get better sleep patterns, all of that but while
7 struggling even at that. And only when we had effected that
8 could we realistically take it to the next level.
9 **Q.** It strikes me, Doctor, that this would be quite a
10 complex treatment in order to put into effect for a former
11 combat soldier. Would that be a fair comment to make? I mean
12 you're talking about stages of stabilization and then treatment
13 of PTSD and then as part of that, or further to that perhaps,
14 treatment of the dissociative aspect of the PTSD.
15 **A.** I'm not even, pardon the pun on words, I'm not
16 dissociating the treatment of dissociative episodes from PTSD.
17 I'm saying, in fact, it's part of it.
18 **Q.** Okay.
19 **A.** It signifies the severity of the PTSD for sure, but it
20 doesn't necessarily require specifically different treatment.
21 **Q.** Okay. There seems to be in the literature some
22 commentary on the difficulty in this aspect of the treatment,

1 which is typically for PTSD. The advisable treatment would be
2 some form of exposure therapy, which would be, in effect,
3 reliving, re-experiencing the trauma and the traumatic event,
4 whereas for the dissociative aspect of it, that may be part of
5 what exacerbates the dissociative episodes or that element of
6 the PTSD. Is that something that you've seen in the course of
7 your work or something that you've reviewed in the literature?
8 **A.** So in real terms you're kind of putting your finger
9 right on what established Cpl. Desmond as a really complex case.
10 So yes, here he is struggling with severe reliving symptoms, and
11 yet again we're asking that treatment requires exposure to the
12 exact same thing that was triggering him.
13 Having said that, though, what it really points out to is
14 how much more effort and how much more work we need to put in to
15 stabilizing him and that in itself almost makes sense of why it
16 was so difficult for us to actually stabilize him thought it
17 doesn't change the approach. It just means it's going to be
18 much harder work and you would invest a lot more time.
19 **Q.** It seems that it would justify even moreso, perhaps,
20 or add justification to your recommendation that he be put in a
21 residential facility to enact that treatment or to forward that
22 treatment.

1 **A.** It did, yes.
2 **Q.** As I review the literature again further on the
3 dissociative disorders there's a note that when left untreated
4 dissociative disorders can lead to such things as depression,
5 anxiety, relationship and work problems, substance abuse
6 problems, difficulty recovering from the original trauma. It
7 would seem that list would ... that Cpl. Desmond's had every one
8 of those symptoms. Would you agree in your observations of Cpl.
9 Desmond and of Dr. Murgatroyd's notes?
10 **A.** Yes, I do agree that he did present very complex. He
11 did have a case of major depression right off the bat alongside
12 his diagnosis of PTSD. He did have a substance use disorder as
13 concurrent with the diagnosis of PTSD. So all of that is true.
14 However, I wouldn't necessarily say the dissociation led to
15 that. I never diagnosed him as a dissociative disorder. What I
16 have been speaking of is dissociative as a symptom and as an
17 expression of the severity of his reliving of flashback
18 experiences.
19 **Q.** I recognize and I wanted to mention, Doctor, that it
20 appeared that you didn't diagnose him with dissociative
21 disorder. Perhaps I would say didn't yet diagnose him with
22 dissociative disorder. If you look at your observations of him

1 those seem to be consistent with what we've heard from other
2 members of his family and other individuals who have observed
3 similar things and it's ... so I want to explore that.
4 I'm not going to ask you to diagnose him at this point
5 based on others' observations but I just wanted to ask you if
6 your observations would be consistent with what we've
7 subsequently learned. So I want to present a few of those facts
8 or some of that evidence to you.
9 First of all, I guess, Doctor, just to put a few things to
10 you, Dr. Murgatroyd did note that Cpl. Desmond did sometimes
11 present as, I think he put it "not being really there". Family
12 members commented to that same effect as early as his first ...
13 he had a two-week break from the time in Afghanistan and came
14 home, and that observation was made on the drive home from the
15 airport that he seemed like a different person or not really
16 there.
17 But it also seems, Doctor, I'll just add this. One of Cpl.
18 Desmond's fellow soldiers noted that Cpl. Desmond maybe seemed,
19 and I'm paraphrasing, particularly innocent as an individual
20 going into a combat situation. And that seems, in the
21 literature, something that might lead to dissociative
22 experiences or dissociative presentation. Is that something

1 that you're familiar with either through your experience or what
2 you've reviewed?
3 **A.** If you're asking specifically about innocence,
4 honestly, that's a phrase I can't say I even understand. I'm
5 not sure what that entails in terms of being a descriptive of a
6 combatant going into a combat area. I don't know what that
7 means. So I'm not sure if that's the answer perhaps.
8 **Q.** Well I don't want to put ... I hesitate to use the
9 word "naive" because that has some negative connotations,
10 perhaps. But that kind of innocence is what I mean.
11 Inexperienced in violent situations or inexperienced in seeing
12 evil or seeing the horrors that could, you know, confront
13 somebody in a war situation.
14 **(13:20)**
15 **A.** I probably am not well placed to comment on that. I
16 would have to say I probably can't. What I can say, though, is
17 that there's something interesting about trauma, particularly
18 when you think about the trauma event. Sometimes it's not so
19 much about simply the severity of the experience or exposure.
20 It's usually a lot more around the significance of that to you
21 and where particularly people get caught up in, say, conflicting
22 a situation. So, I thought I was a good guy, I went into a

1 situation, I've done something at odd significantly, profoundly
2 at odds with my sense of self or my sense of worth.
3 So it's those kind of situations that ultimately do set up
4 the whole PTSD experience. How to relate that to be naive or
5 what, I really can't. Because it happens to literally most ...
6 if I would call it moral injury that's what we ... that's the
7 terminology to sort of explain that. And it's a very particular
8 experience for literally all of our trauma patients.
9 **Q.** So something that undermines someone's moral ...
10 **A.** Core beliefs. Core sense of self, yeah.
11 **Q.** Yeah. Yeah. And of course ...
12 **A.** Of the world.
13 **Q.** And of course everybody is going to go into a combat
14 situation with at least slightly different senses of that moral
15 self.
16 **A.** Yeah. Yes.
17 **Q.** So, Doctor, I'd like to walk you through sort of some
18 of the, I think, key events of the final days of Cpl. Desmond's
19 life prior to January 3rd, 2017 and of that day.
20 My friend Ms. Miller referenced a motor vehicle accident
21 which was something that took place on New Year's Eve leaving a
22 New Year's Eve party, and Cpl. Desmond was driving and put his

1 truck, a truck that had just been purchased by his wife, into
2 the ditch. Didn't sound like a particularly serious accident,
3 no injuries or real damage to the vehicle, but he had a hard
4 time. He had a hard time processing it and had a hard time
5 dealing with the fallout of that it seems.
6 Then the next day, January 1st, Cpl. Desmond, over the next
7 ... sorry, January 1st he attends a church service which seemed
8 like an unusual thing for him. He went to a Jehovah's Witness
9 church service. Some of his family members were there as well.
10 He also went to the hospital and spent a night at the emergency
11 room that night. The following day, January 2nd, I don't want
12 to mix up the timeline too much.
13 The night before he did attend at the hospital and was seen
14 there by a psychiatrist. Then, in fact ... I'll push ahead a
15 little bit, I guess, to January 3rd, Doctor. I don't have the
16 timeline of the events in front of me right here but I'll go
17 through some of the events of January 3rd.
18 So there were some future-oriented events that Cpl. Desmond
19 was doing. He was ... we see his search history on his phone.
20 He was looking at houses, looking at gym memberships, returned a
21 pair of shoes. That sort of thing. But also, he had a call
22 with his therapist on January 3rd about close to half an hour

1 long. She described him as difficult to ... you know, he was
2 difficult to understand but she did end the phone call with a
3 plan that if he felt anything that he was going to call her or
4 call somebody or go and report himself to the hospital.
5 There is some report as a result of that conversation that
6 he had had another discussion with his wife that afternoon or
7 sometime that day and she had talked about divorce again. It
8 sounded ... it's hard to tell, but it sounded like maybe a more
9 certain conversation than previous conversations. So he speaks
10 to his therapist about 3 o'clock that afternoon, Catherine
11 Chambers. He had re-booked, also that day, an appointment to go
12 back to the hospital to speak to the psychiatrist.
13 But then later that afternoon we have video of him at the
14 Leaves & Limbs gun store patiently as a customer waiting his
15 turn, purchasing a used firearm with a scope, which was unusual,
16 perhaps, in its own right given how he committed the homicides
17 later that day.
18 And then there's ... he drives from Antigonish where the
19 gun shop was located about 20 minutes back to his home
20 community, and the evidence suggests that he got changed at that
21 point into some camouflage clothing, drove a vehicle not
22 directly to his house where his wife was but instead drove into

1 a woods road that was nearby, exited the vehicle, walked through
2 the woods to the home, slashed the tires of the truck, the same
3 truck that he had put in the ditch, the new truck that his wife
4 had bought, and then entered the home and committed the
5 homicides and killed himself.
6 It's not a hundred percent clear, Doctor, that he would
7 have known his wife and mother were in the home. We don't have
8 clear evidence on that point but ... sorry, that his mother and
9 daughter were in the home. He certainly would have known his
10 wife was there, I think, given the truck was there.
11 So I know that's a lot to take in, Doctor, but that's the
12 sequence of events as we're aware at this point. And so I would
13 invite your comment ... and if you have comments about the
14 sequence that's fine, too, but in relation to potential
15 dissociative experiences, I guess one question would be, could
16 those events ... and I'm thinking specifically of the truck
17 going off the road and his wife telling him, perhaps for
18 certain, that afternoon that they were getting divorced. Could
19 those be triggering events, and does the sequence of events fit
20 or not fit with what you might understand a dissociative episode
21 to involve?
22 **A.** Honestly, it's difficult to comment, to be very

1 honest. It's really hard to look so far into that and try and
2 put all of that together. I would be hard-pressed to make a
3 clear comment in that way and I would be hesitant to start
4 throwing out conjectures, honestly.
5 **Q.** Would there be elements of what I've just told you
6 that would be consistent or inconsistent? I mean as you're ...
7 I can understand not wanting to, I guess, venture an opinion,
8 especially where there are so many uncertainties. And we still
9 have some uncertainties. But if you were to pick out particular
10 elements of what I've just explained would there be individual
11 aspects of that that you might wish to comment on in terms of
12 dissociation?
13 **A.** Not really. Except, perhaps, to say that the elements
14 of dissociation related to PTSD would, of necessity, be related
15 to the trauma event and him reliving it and responding to it.
16 So that's all I could probably venture. Which of them relate to
17 his trauma, I can't even pick up just now.
18 **Q.** Would it seem, Doctor, that putting on the camouflage
19 and having a weapon and going through the woods would ... and
20 maybe I'll ask it in a more broad sense. When an individual
21 feels like they're back in Afghanistan or they're back into the
22 trauma is that ever ... does that ever manifest itself in

1 actually acting as though a person is in Afghanistan or back in
2 a traumatic situation?
3 **(13:30)**
4 **A.** It would. Sometimes, yes. Because that's the point.
5 It's a reliving. So you're literally in the place. You're
6 literally going through whatever that trauma experience is. If
7 you're fleeing, you'll be fleeing. If you're ... if you are
8 attacked you will be shouting out. You will be calling the name
9 of the person. You'll be ... you know, all of that. He
10 wouldn't be calling your name. He'll be calling the name of his
11 assailant from his original trauma and he will be responding to
12 you in that manner.
13 Just like he would have in nightmares. So sometimes ...
14 and that's actually the point. So reliving and daytime
15 flashbacks are kind of reflective of what happens in nightmares.
16 So if you ask a spouse or a partner they would say, Oh, you were
17 talking about this or you were flailing and acting this or you
18 were sort of barking out commands in this way.
19 **Q.** We do have one report, Dr. Njoku, of Shanna, his wife
20 ... of Cpl. Desmond waking up with his hands around Ms.
21 Desmond's neck and she had to snap him out of what she felt ...
22 or as she describes it, seems to have been perhaps a

1 dissociative episode. So that's ... so we've seen that a few
2 times here with Cpl. Desmond.
3 Just to get back to that, I guess. Would you view, Doctor,
4 the discussion ... and we're not sure about this discussion.
5 But if there was one solidified, Yes, divorce is happening,
6 you're going to be ... you know, she was, in effect, his main
7 support in many ways. Could that have been a traumatic enough
8 event to trigger a dissociative episode or would it need to be
9 something more physical and more directly connected to a combat
10 situation?
11 **A.** For the dissociative episodes related to PTSD it would
12 be related to combat. So it would be a cue that triggers remind
13 you of combat. So it could actually be ... I don't know, a
14 smell, a certain smell, a certain song come up, certain time of
15 day, certain environmental ... so it could be anything. But the
16 key is that it would be a cue that triggers the recall of the
17 original trauma.
18 So for PTSD specifically, say, divorce would probably not
19 count as that because ... well, you don't equally overlook
20 things like hypervig- ... hyperarousal. So because they are
21 already fired up, they're already quick to anger, they're
22 already quick to ... they are very irritable and on edge, yes,

1 he will be angry and he might be extreme. But that wouldn't
2 necessarily be PTS- ... it wouldn't necessarily be a
3 dissociative episode.
4 **Q.** Could you ...
5 **A.** Right? The dissociative episode in itself means he is
6 completely out of his control, whereas these other ones would
7 probably be an exaggerated response what will be in his control
8 just like, I will chase you down if you cross me on the highway
9 or something.
10 **Q.** All right. Thank you very much for that answer,
11 Doctor. I think that's helpful for us and thank you for your
12 testimony today. Those are all the questions I have.
13 **A.** Thank you. Thanks.
14 **THE COURT:** Thank you, Mr. Rodgers. Mr. Haynes, do you
15 have any questions?
16 **MR. HAYNE:** No questions.
17 **THE COURT:** All right. Thank you. Mr. Murray, do you
18 have any follow-up questions?
19 **MR. MURRAY:** I just have one, Your Honour.
20 **THE COURT:** All right.
21
22

1 **RE-DIRECT EXAMINATION**

2

3 **MR. MURRAY:** Dr. Njoku, the questions that my friend, Mr.
4 Rodgers, asked you about, I guess, attempting to determine the
5 intent of Lionel Desmond or his state of mind prior to his
6 death, are those better directed at a forensic psychiatrist?
7 **A.** Possibly, yes. Possibly.
8 **Q.** Or is it possibly for any professional to answer those
9 questions?
10 **A.** It would be impossible to answer in retrospect. It's
11 easier to answer if I had this one and I had that account and I
12 had all of his historical accounts and I do a full-on clinical
13 review with Desmond and then I put all of that together. So
14 that's what a forensic review would really mean.
15 If you're asking forensic in terms of the police forensic
16 work, then maybe that's different, but from the psychiatric end
17 of things, forensic ... I would also have to assess him to put
18 all of that together. So it leaves it difficult to do ... make
19 a retrospective sort of diagnosis.
20 **Q.** Right. All right. Thank you, Doctor.
21 **A.** Yes.
22

1 **EXAMINATION BY THE COURT**

2

3 **THE COURT:** Dr. Njoku, I am just going to ask you. It's
4 kind of a question and it's just to make certain, I guess, that
5 I have an appreciation for what you are saying about some
6 aspects of the dissociation. So as I understand it, there is a
7 particular disorder, dissociative disorder, and it is a
8 particular diagnosis. Is that correct?
9 **A.** There's a disorder, Dissociative Identity Disorder,
10 yes. There's a clear diagnosis.
11 **Q.** Okay. And you can have dissociation events or
12 episodes that are a symptom of something else. Do I have that
13 correct?
14 **A.** Yes, sir.
15 **Q.** Yeah. All right.
16 **A.** Yes, sir. Yes, Your Honour.
17 **Q.** All right. That's just ... I just wanted to clarify
18 that in my own mind.
19 Dr. Njoku, I appreciate that it's taken some considerable
20 time to prepare for today. I know you've reviewed some records,
21 and I can appreciate that recalling some of these events are
22 difficult. We certainly appreciate your time and your insight,

1 the information that you've given us today, and I know it's of
2 value. I know I've gained some additional insights today that
3 are valuable in terms of what I have to do here after we've
4 heard all of the evidence and conduct our review and perhaps
5 make a recommendation.
6 So again I'd like to thank you for your time, sir. We
7 appreciate it.
8 **A.** Thank you, Your Honour.
9 **Q.** All right. Thank you.
10 **A.** Thank you, sir.
11 **Q.** All right, and thank you, Mr. Browne. All right.
12 Thank you, then.
13 **MR. BROWNE:** Thanks for the opportunity, Your Honour.
14 **THE COURT:** Thank you.
15 **WITNESS WITHDREW (13:37 hrs.)**
16 **THE COURT:** All right. Thank you. I think we're done
17 for the day. We're going to adjourn for the day. Next week we
18 have witnesses that are scheduled for the week that are
19 primarily from Quebec and we're going to try and make some
20 arrangements so that they'll have all the documentation
21 available to them in the event that we have any document display
22 interruptions ourselves here. Hopefully not. We've been fairly

1 successful overall apart from just some minor events.
2 So thank you very much, Counsel, and have a safe and
3 enjoyable weekend. We'll see you next week.
4
5 **COURT CLOSED (13:38 hrs.)**
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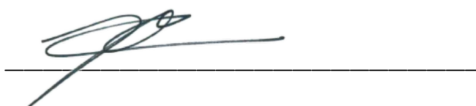
CERTIFICATE OF COURT TRANSCRIBER

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



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March 10, 2021