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: June 22, 2021

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

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

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

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

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

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

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

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

INDEX

EXHIBIT LIST

EXHIBIT LIST

JUNE 22, 2021

COURT OPENED (09:30 HRS)

THE COURT: Thank you. Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: I understand this morning we have Ms. Doucette with us. Good morning ...

MS. DOUCETTE: Yes.

THE COURT: Good morning.

MS. DOUCETTE: Good morning.

THE COURT: Good morning. Ms. Grant?

MS. GRANT: Thank you, Your Honour.

MARIE-PAULE DOUCETTE, affirmed, testified:

THE COURT: Go ahead, Ms. Grant.

DIRECT EXAMINATION

MS. GRANT: Good morning, Ms. Doucette. How are you this morning?

A. I'm okay. Thank you.

Q. Just before we start getting into this, just to know during the day that we often have a mid-morning and an afternoon break and a lunch break as well. But if you need to take five, then let us know and we can see if we can facilitate that for you.

A. Thank you.

THE COURT: In addition, Ms. Doucette, because we are doing this by video conference and sometimes the audio will break down or sometimes the video and there'll be a pause in it, if you have any difficulty like that, if you could just let us know. We have some limited ability to make some adjustments but it can be quite distracting for everyone if we wind up with that kind of electronic interference. So if you notice anything ...

MS. DOUCETTE: I'll let you know.

THE COURT: All right. Thank you.

MS. DOUCETTE: Thank you.

MS. GRANT: So just before we begin, you did review some documents in advance of your testimony today. Correct?

A. Correct.

Q. And those were documents that you were provided by counsel, me and Ms. Ward?

A. Yes.

Q. And just ... I think it would be helpful for the day, because you'll probably be with us for the bulk of the day, if we talked about some of the documents that we might be referring to so that people in the courtroom and people who are watching will know what we're talking about.

A. Okay.

Q. And the focus, I think, will be on documents that you had authored or authored in part. So I just want to mention those for the benefit of the Court, that we might be putting those up at some point. But we don't have to put them up right now. So an Area Counsellor Plan Centered Assessment. And just for clarification, "area counsellor" is what ... case managers are now what area counsellors were. It's the same job.

A. Yes. Yeah.

Q. And so that's going to be Exhibit P-291. And then you worked on what's known as a Rehabilitation Case Plan ...

A. Yes.

Q. ... and that's Exhibit 117. And you worked on a Regina Risk Indicator Tool and that's ...

A. Yes.

Q. ... Exhibit 277. And then there's another document and that's ... I guess I should note the Rehabilitation Case Plan, we'll get into that, but that's a Client Service Delivery Network accessible document.

A. Yes.

Q. And then another Client Service Delivery Network document. It's something that we're referring to as Client Initiated Screenings and that's Exhibit 292.

A. Yeah.

Q. And then we produced what we're referring to as a companion document because it was hard to read. It was quite blurry and illegible in parts. So we got that information from the system and that's Exhibit 293. And then in the Client Service Delivery Network, you would put in notes and we'll talk about that a bit more, but that is Exhibit P-273.

A. Yes.

Q. And then you also made some notes after the events of January 3rd. Correct?

A. Yes.

Q. And those are ... I think I have a typo in mine. 299, I think? Yes. Okay. So just to get that out of the way so we know when you refer to something we know generally what it is.

Starting with your background and education ...

A. Sure.

Q. ... what's your current situation, just generally?

A. Okay. My current situation is I'm working for the federal government in a different department doing Employee Assistance Program, so delivering services, crisis intervention, and short-term mental health counseling. I recently moved back to my home province, so in the process of having my job transferred to the region.

Q. You're in New Brunswick now.

A. Yes.

Q. And can you tell us a bit about your education?

A. So right out of high school, studied at St. Thomas University, obtained a Bachelor of Arts. I was a student in the Journalism Program. So that was my major and then went on to do a Bachelor of Social Work post degree, so essentially an

accelerated professional program for people who already had a previous degree. And then went ... well, returned to the workforce. I worked a little bit in the community sector before that, but returned to the workforce as a registered social worker. And over ... between 2013 and 2016 completed my Masters of Social Work, part time, from Memorial University this time.

Q. Thanks. And when did you join the federal public service?

A. I joined the public service in 2011. At that time, I was hired as a community parole officer with Correctional Services Canada.

Q. And how long were you at that job? Sorry.

A. I was at that job for close to four years, between three-and-a-half and four years, before I transferred over into Veterans Affairs, which was a lateral move. I guess in federal terms, it was an equivalent position in terms of classification.

Q. Okay. And when were you at VAC?

A. I arrived at VAC in September of 2015 and remained there, I guess on record, until April of 2019. But in January 2018, I took what we call a personal leave. That's something you can do once in your career to go work in the community sector for a change of scenery. And then I guess my position

with Veterans Affairs officially ended in April of 2019.

Q. Was that at McGill that you were ... spent some time in?

A. No, not right away. So when I ... in January 2018, I left and worked ... I was living in Montreal and went and worked in a non-profit organization in the eastern part of the city. It was essentially focused in helping families of children and youth at a disadvantage. And it's called "social pediatrics", if there's anyone who's familiar with the term.

So my job was to do ... I was part of the knowledge transfer team. So I helped centres across the province sort of deploy their own services. And so I did that for close to a year until I was due back. Eventually did go on and get a position as a short-term mental health counselor at McGill University part time. And when I returned to the public service, it was in a part-time ... also in a part-time capacity. So I held two part-time jobs.

(09:40)

Q. And so just in terms of a roadmap for the next little while, we're going to talk about your general role at VAC and as a case manager. And then we'll go into more about the interactions that you had with Lionel Desmond. And we'll try to

do that in as chronological an order as we can manage is the goal.

A. Sure.

Q. So talking about the role of a case manager, in your own words, can you describe the job of a case manager? What does the case manager do?

A. Case managers do obviously multiple things. I'd say the focus of our work is accompanying veterans who are facing barriers in their transition into civilian life. What that translates to is we basically inherit a caseload of veterans. I might also use the term "client" sometimes interchangeably but ... out of habit.

So we have a caseload. So it is our job to do an initial assessment which you referred to earlier on. And from there, collaboratively build a case plan or a rehabilitation plan, if it's through the rehabilitation program, with the veteran.

And then the focus is to sort of help coordinate the services that they need to reach their rehabilitation or case plan objectives. So our job is to approve resources. We do a lot of consultation with internal, I guess, ministerial experts, if you wish, and also private providers in the community.

Another part of our job is to ... aside from the caseload

that we have is we also receive applications for the rehabilitation program and the case managers are the people in the department who have the ... I guess, the legal authority to approve or deny entry into the rehabilitation program. So sounds simple but it's a bit of a process.

So we would receive the application and then it was our job to contact the veteran because a lot of the time the application was either incomplete or missed some supporting evidence. So we would call them to make sure that the application was complete and then receive the extra supporting documents needed and then render a decision.

And part of rendering that decision could involve consultation again with rehabilitation ... I forget the name of the ... we had people who specialized in the rehabilitation program. We had mental health officers. So depending on the conditions for which they were applying, we had consultations to do, interdisciplinary teams sometimes.

And we also had the responsibility of rotational intake duties. So you may have heard of intake duties through the Inquiry process, essentially to make sure that veterans, whether they are case managed or not, have access to a case manager as needed during work hours.

There was always, I think in the New Brunswick office, I'm not a hundred percent, but I think there was always two of us daily on ... not on call, per se, but on intake. So on top of managing your caseload and the demands that come through that, you are to be available and to prioritize demands that may be coming urgently from clients of colleagues who are away or, again, clients who are not yet case managed but are dealing with specific difficulties that ... I guess of case managers in the best position to deal with or to support with. If that makes sense. Does that make sense? So I guess in my own words that it's in a nutshell but, obviously, a lot of administrative tasks associated to the position.

Q. And can you talk a little bit more about that, the administrative tasks?

A. Yeah. Sure. Well, essentially, we would have requests coming from many directions, whether client providers who are offering services to the client maybe coming from the VSTM, so the team managers. They could be coming from another colleague like a veterans service agent, for example, who has had an interaction with a veteran and they determine that this is more of a case manager question or issue.

And then we are expected to document the work that we do,

so you reference client notes. So as much as possible we write down the interactions that we've had. And when I talk about rendering decisions, it's not as simple as, you know, clicking a yes/no box. You have to, you know, quote your legislation, speak to the evidence that you're using to support. So although we are in charge of making the decision, we have to collect a lot of information, consult, like I said before, and make sure that our decisions have a solid rationale. So a lot of ... yeah.

If you've seen an example of a case plan and what a resource screen looks like, that would give you an idea of, you know, what a decision might look like or ...

Q. And would all ...

A. And ...

Q. Sorry. There's a little bit of a lag. Keep going.

A. Right. Well, I was just going to add and the same when we're doing intake duties, as I mentioned earlier. So when I worked in New Brunswick we were on intake for a week, so five days, every six weeks or so depending on your language capacity and all that. And then, again, that ... you never knew what administrative tasks you may be required to do on any of those days because you would just take the call and then from there

determine ... sometimes it could be a financial emergency, it could be ... but each of these calls required time to document and consult, et cetera, so ...

Q. And can you maybe give us a sort of day in the life of what you would ... if there was a typical day ... and maybe there isn't but if you could talk about what a typical day might look like.

A. Yeah. A typical office day ... because we do go on the road to visit clients especially when we're meeting them for assessment for the first time. So I don't know if there is a typical office day. You can definitely come in with a plan to, Okay, today I have "X" decisions to render. You can be referring to the work items that our system generated. Or I have to move ahead with this case plan, so I have "X" number of phone calls I need to make to make this rehabilitation plan, I guess, advance with their rehabilitation plan.

But then what's typical about every day is that you receive a lot of phone calls and you don't know who, on your caseload, may be calling that day. So at times you could plan that your day was going to look a certain way but it seldom turned out that way. So in terms of managing priorities, I would say is huge for case managers, so determining, okay, well, in that

moment what's more important and et cetera, et cetera.

But we were expected to be available for our clients as much as possible. So daily phone calls, I don't know what an accurate average would be but, you know, five phone calls on average a day, I don't think would be exaggerated. There's some days you would have 10, 12, other days maybe have a little bit less, but ...

And on the road ... so essentially what we would do is when we have a new client or veterans newly assigned to our caseload, the expectation is that we go meet with them, preferably in their home, if they're comfortable and, if not, it could be in a location of their choice. And, you know, we come to them. The option to come to the area office is there but it's never an expectation.

So the case manager will travel and sit with them, generally a meeting to conduct an assessment and it depends on the person, but you could plan for a solid two hours; you know, getting to know the person and getting through the assessment. And sometimes it would be done in two sittings, if it was ... you know, we had some veterans with chronic pain for whom it was hard to sit for any length of time so ...

(09:50)

But when we were on the road, what we were expected or encouraged to do was to have a number of veterans that we would see within that day. So you rarely would take a day to go visit only one person. So you would schedule two, three, sometimes four if you can fit that in. And, yeah, so there were days where we were not in the office. Maybe, I don't know, three, four days out of the month, something like that.

Q. And just to, I guess, continue this discussion about what case managers do, can you give us some examples of what case managers don't do?

A. Sure. Case managers ... well, we don't obviously force services on anybody. We're there to, you know, recommend and counsel on options but, ultimately, the veteran being a voluntary client is in charge of their own decisions. And so, yeah, we don't force services. That's, I think, pretty important.

We don't provide emergency services 24 hours a day, seven days a week, that sort of thing. We're generally available in work hours. It doesn't mean that a case manager will never do an odd call after working hours if, you know, it's a really busy week and they need to get to ... but that's on us. We don't typically take calls in the evening or anything like that.

We don't monitor, sort of daily, what veterans are up to. It's very much a ... you know, we build a relationship with them and it's about trust and each have their sort of ... I don't want to say "end of the bargain", that kind of sounds pretty informal. But we both have our ... what we agree to do and we trust that the veteran is going to do their part of the agreement.

We don't ... well, we're not ... in a case manager capacity, we're not an adult expert. So, yes, we do assessment and that is, you know, an initial important step in the case management process and it's an evolving process, as well. But we refer out to specialists who are the people responsible of really doing the therapeutic work with ... and that could be at a physical/medical level as much as a psychological mental health. So we're generalists, I guess. We're not subject-matter experts. I may think of other things that we don't do, but for right now that's ...

Q. And your background with your Masters in Social Work, do you find that that background was helpful to you as a case manager?

A. Absolutely. A Masters of Social Work is not a requirement to be a case manager. A Bachelors of Social Work is

sufficient. But, obviously, in furthering your education, it provides a lot of opportunities to reflect on the work that you do, especially where I, you know, did it part time, one course at a time. So I was working at Veterans Affairs when I completed in the later stage of my Masters. So, yeah, absolutely, there were assignments and, you know, different projects or whatnot that we are expected to do that you could connect to your daily work, the realities of the clientele that you worked with. So, yeah, I'd say that was helpful.

Q. So working with clients and I guess ... is it fair to call social work one of the "helping" professions?

A. Yeah. Absolutely. I'd say almost purely a helping profession. It's one of those professions where you are ... unlike ... although there are other helping professions like nursing or whatnot, our tool is ourselves and the capacity to build trusting relationships with clients and to problem solve.

Q. So just to kind of build on that and what you mentioned about trust, there's sort of a ... from what I've read, anyway, there's sort of a core function of a case manager in terms of like a job description. So since this isn't a test, I'll read them and then you can agree or disagree if I don't have them all, but core functions, engagement and relationship

building?

A. Absolutely.

Q. Assessments?

A. Yeah.

Q. Analysis?

A. Yes.

Q. Case planning and consultation?

A. Yes.

Q. Monitoring and evaluation?

A. Yes.

Q. And, as applicable, disengagement?

A. Yes. Yeah.

Q. Can you talk a little ...

A. Yeah, that would be accurate.

Q. Can you talk a little bit more about engagement and relationship building in the context of working with veterans?

A. Absolutely. It's a huge piece, engaging with veterans from the onset. I mean you asked about, you know, how my Masters degree was helpful to my work. But one of the things that we know through our field is that quality of the relationship with the client makes a huge difference in success rates.

So we definitely ... rehabilitation can't happen without engagement and, you know, we have the responsibility to try to build a sound and solid relationship with the veteran. It's different with every case. With some people it can take months, with some people it can take days. It really depends on their prior experience of working with a helper.

And in the veteran community specifically there was, you know, a number of veterans that I can recall in my caseload who were being medically released from the Armed Forces prematurely and often, in their perspective, they could be engaging in case management services at VAC for the first time a bit dissatisfied with how their career with the Forces ended. So that would often carry over into the work that we did.

So the engagement process involved a lot of listening, validating their experience, and then if you see in the media, you know, sometimes VAC doesn't get always the best reputation with the clientele so another reality is that veterans would come in and have all kinds of preconceived notions about what rehabilitation is, what services they're going to be eligible for, because they talk amongst themselves as colleagues and friends and some will say brothers.

And so there's a lot in the engagement process of

clarification that we need to do in terms of what actually case management and rehabilitation is and sometimes what benefits can actually be approved versus not approved. So, yeah, it's an important process and I think it starts from the first phone call and can carry into, like I said, several months into the working relationship.

Q. So the initial step then is the case manager or area counsellor assessment when you were there.

A. I guess administratively speaking, yes. Generally, the very initial step is a person is assigned to our caseload by a veteran service team manager and then we are going to contact with that veteran to introduce ourselves, you know, explain our role, and then try to find a time, in a timely fashion, to meet with them.

(10:00)

Because of the way things work and because of, you know, large caseloads and whatnot, sometimes the veteran would end up calling us quickly and then we might engage that way. But, usually, the very first contact is over the phone and then we follow up in a face-to-face, in-person, visit for the assessment. **Q.** And what's involved in case planning and making a rehab plan, generally? They probably vary greatly.

A. Sure. Well, after the area counsellor's admittance call or we do our initial assessment, a number of needs are identified and from there we look, with the veteran, what their goals are for their rehabilitation program, so what is it that they would like to accomplish, what barriers are they facing that they would like to overcome. So we collaboratively set the objectives and that's basically the start of the case or rehabilitation plan. And we, from there, determine how we will go about meeting these goals, what services are needed, so what needs were identified in the assessment and what services can we turn to to address this need.

So in case planning, we would have like a sort of ... I usually called it like an umbrella objective that the veteran ... we would help them create and, from there, smaller action steps so that you sort of chew off one bite at a time because rehabilitation can be an intensive process and so ... yeah.

And then as the days and months go on and services take place, it's our job ... when you mentioned monitor and evaluate, so with the help of the providers to determine, Okay, are they progressing? Are they reaching their goals by whatever target date? And it's not the end of the world if they don't reach a goal, but we revisit them throughout the rehabilitation process

or case planning process.

Q. So is this ... the case plan is made jointly with the veteran.

A. Absolutely. Yeah.

Q. And the focus, is it on meeting that person's specific personal priorities?

A. Yes.

Q. So part of the ... we talked about earlier, part of the case manager's role is decision-making over authorizing resources. Is that right?

A. Uh-huh. Yes.

Q. And what would be the sort of scope of your authority as the case manager?

A. Well, in terms of the rehabilitation program, case managers are sort of the authority in approving services via this ... I don't know if you'd call it a "stream" or whatnot, because there's different ways that veterans can access services, but to approve anything under their rehabilitation program, that is a case management specific responsibility. And I think the team managers have some odd things that they can approve, as well, the area directors.

Sorry. Can you repeat your question?

Q. Yeah. Sure. And just to kind of focus it a bit more, are there people that you would consult with in the course of authorizing services?

A. Oh yeah. Absolutely. Yeah. So, you know, the veteran is driving the case plan. We are there to coordinate services, but we are trained and it's very much expected of us that we will consult. So we don't ... we make decisions, we render decisions but it's never just based on our own interpretations or ... we need evidence.

So evidence can be sometimes coming from a professional who is engaging with the veteran; could be a psychologist, could be a physician, could be physiotherapist. And then, internally, we have STEOs which are policy experts. So although we really try our best to be creative and approve as much as we can for the veterans, sometimes there were things that were asked of us that it wasn't clear that we had the authority to approve.

So consulting with the policy experts, their rehabilitation officers, I forgot the term earlier, but there were people who were really trained in everything rehabilitation program. So what can be approved within the rehabilitation program and, if not, are there other avenues to approve resources and services.

We had a regional mental health officer who are extremely

helpful. I mean they brought sort of a focus on psychological mental health needs and so if we're going to be approving a resource, inpatient treatment is a perfect example. It's a very costly resource. It involves a lot of planning. Then we might consult a mental health officer to say, Okay, I have these recommendations. This is what I've ... they look at what we've documented over time. So they just sort of join in with you on determining if "X" treatment would be a good fit or sometimes ... they're not there to tell us what to do but sometimes they may propose, Oh, have you thought of this other avenue, et cetera.

So mental health officers and then the interdisciplinary team is made up of some of these people that I mentioned, the veteran service team manager. We have nurses, occupational therapists who sort of work within VAC, so who brings that sort of ... they're more, I guess, a more precise clinical lens from their field. So if there was ever some kind of concern with medication, for example, a nurse could provide a bit of input and whatnot.

Q. In government, we speak in acronyms. So I just wanted to go back to some of the terms that we see in some of the paperwork. So you mentioned a STEO, S-T-E-O. What is that in

...

A. STEO is a standard training and evaluation officer, I believe. So when we refer to policy experts, STEO is like ... when we start as case managers, for example, and we have national orientation programs that we're expected to complete, the STEOs are generally in charge of ... it's a big training portfolio and they're generally in charge of that. There is many policies at VAC, so if there is ... you know, we're trying to find justification for something or to clarify if such and such is possible, a STEO is like an excellent person that we can refer to to guide us through the numerous policies and whatnot, so you know, you search but if you really can't find, then there is these experts that you can lean on.

Q. And what about, you mentioned it just a few minutes ago, veteran service team member. So we've seen it as a VSTM acronym. So what's their role?

A. Yeah. So when I started, they were actually called CSTM, client service team managers. Then to be more veteran centered, there was a change in the terminology. So the veteran service team managers are responsible for the front-line teams. So the case managers ... like one VSTM would have sort of a group of case managers and a group of veteran service agents

assigned to their team. And their job was to assign cases to sort of ... if a veteran ever had a complaint or wanted to speak to another sort of level above us, then the veteran service team manager can get involved. So they have some direct contact with the clients, but it's usually ... it's not the main focus of their job. The main focus is about coordinating services like the team who are delivering the services.

Q. And the mental health officer, I think we've seen as an MHO. Is that when we see that ...

(10:10)

A. Yeah. Sometimes RMHO, regional mental health officer, because there was one or two assigned per every region. Yeah. So they were, like I said, a person who just focused really on mental health aspects of our clients and ...

Q. Okay.

A. I'm trying to think.

Q. And IDT.

A. Well, they usually had ... I was going to say that they were usually someone who came with a mental health specific background. Like it wasn't just someone we'd pick out of thin air, kind of thing, so ... An IDT, the interdisciplinary team, is sort of made up of all these people. At VAC, there are

physicians, nurses, occupational therapists. So they usually sit around the table.

When I worked there ... like the physicians are very much involved in everything to do with disability awards. I know they're called something different today, but when I was there ... so they would ... if a veteran needed to have a disability reassessed, for example, then they could consult the VAC physician, the one on ... so we could turn to the physicians, if needed, in case management. They weren't, in my experience, the people that we consulted the most but they still remained a resource.

So when we went into IDT, usually there would be a physician around the table that sort of brought the medical practitioner expertise and same with the nurses. I think, historically, nurses work more with our elderly veteran population. So everything to do with long-term care and helping the veteran stay home if that is the process, so ... but, again, they were sitting at the interdisciplinary table. So we could use that opportunity to consult with them if we felt that, Hey, it could help with a specific question or whatnot.

And the IDT, in my experience, is usually organized by a veteran through the team manager. So there would be ... I think

once a week, they would organize an IDT meeting. And if you had a case that you wanted to present before the IDT meeting, then you had to just sort of prep the team, provide some details about the case and then show up for the meeting when it was your turn.

Q. So we heard from Lee Marshall that not every veteran has a case manager assigned to them. Is that your understanding?

A. Yes.

Q. And a case that comes to you, would it be somebody obtaining a case manager because they have multiple or generally have multiple or complex needs?

A. Yeah. I think it's fair to say they generally have multiple needs. I've seen very few people ... I can think of maybe a few veterans that I've worked with in case management who had, you know, a single injury.

For the most part, when someone is referred to a case manager, there is sort of overlapping medical and psychosocial needs that need to be addressed and then there's the vocational aspect, as well. So the people who come into the rehabilitation program tend ... not all, but tend to be people who are facing roadblocks into re-establishing into like a civilian career.

So I mean we see, as case managers, a portion of veterans ... there are many, many veterans who transition from the Forces into careers in the civilian world, if we can call it that, and without major difficulties. So you don't tend to see those people as much in case management.

Q. And you might ... you've talked about some of the services earlier, but just any other services you can think of that case managers arrange?

A. Arrange? Yeah. Well, psychologist is a big one when we have ... or mental health counsellors when we have clients who have psychological needs that need to be addressed. Anything to do with pain management, physical injuries, so sometimes physiotherapy and sometimes veterans will be approved for like a multidisciplinary ... call it a clinic or whatnot, but where they would have access ... like a one-stop shop for physio, occupational therapy, maybe counseling, like depending on how the team is set up. So there were those sort of services that you could approve. What else? We approved ... I'm trying to think. There's definitely more. I'm just drawing a blank.

Q. What about OSI, occupational stress injury clinic?

A. Yeah. So occupational stress injury clinics fall generally in like the treating psychological/psychosocial needs.

The approval process is different with OSI because of agreements between levels of government. But, essentially, case managers outside of certain professionals in the Canadian Forces are the people who can refer to OSI. Absolutely.

But we don't approve like ... we didn't approve OSI services in the same way that we would approve a private provider in the community. It wasn't like a ... I think they call it fee-for-service or ... it was a different model. But, yeah, we were sort of amongst those people who could produce a referral.

Q. And can you talk about if you ... your answer was "yes," so is one of the services a case manager can arrange, a clinical care manager?

A. Yes. Yes, absolutely. Clinical care manager is a very unique resource and I've never heard of such a resource outside of Veterans Affairs. And I guess in layman's terms, the best way I could describe a case manager ... a clinical care manager is it's like an extension of a case manager. So it's someone that we can contract out for a temporary period to come in like when we know there may be additional help needed for a period of time, whether it's to just stabilize a situation or sometimes there's multiple providers and appointments, and the

veteran may need a little extra help organizing that sort of stuff. So clinical care managers come in in situations like that.

Q. Okay.

A. It's a really nice resource, in my opinion, but not something that we use in all of our cases.

Q. Is there ... this may be an unfair question, but do you have a ballpark of how many cases that you were involved in would have a clinical care manager?

A. Like myself alone? Well, I don't know. I can't say for sure but I've definitely contracted out case managers in six to ten cases maybe.

Q. So, again, like a veteran doesn't get ... not every veteran gets individual care ... clinical ... sorry, a case manager. They also don't ...

A. Care manager.

Q. ... get a clinical care manager.

A. No. No. It's very much a temporary resource that we can go get when case management hours, if we can put it that way, because like in a simple way like are not sufficient to help a veteran with "X" situation.

Like an example of times where we've used clinical care

managers, certainly where there's a certain complexity to their needs, but also when a veteran relocates to a new area and it happens and ... because life goes on even though you're in rehabilitation. But then when you ... the fact that you moved to a new province generally means a bunch of new providers have to be secured. So that would be an example of when a clinical care manager can provide additional help in helping find the resources and helping the veteran connect to ...

(10:20)

Q. Do veterans ever call with suggestions or names for treatment?

A. Oh, yeah. Absolutely. Like providers, veterans would often say ... we did the assessment, we are billing the case plan and we ... they agree that, for example, psychological treatment would be beneficial to them and they'll say, Well, I've heard of so-and-so in Oromocto that practices and I would like to engage with that person. So then at that point our job becomes, Okay, so you know how to reach this person. If not, we can help them find a number, whatnot, and then just making sure that the provider is registered with Medavie Blue Cross and that's a simple phone call for the provider.

So, yeah, they would often already have a good idea of who

they'd like to work with, again because they speak amongst each other; you know, One of my fellow CAF members has gone to this person and received great service and so ... yeah, that'll happen.

Q. The Medavie Blue Cross piece, is that ... not to get into the nitty-gritty, but where Blue Cross is involved, does that mean the veteran is not paying out-of-pocket?

A. Generally, yes. So Blue Cross is sort of the insurer, if you want. Like VAC can authorize services but it is through Blue Cross that the treatment is paid for. And rehabilitation, that is sort of a particularity of ... I'm trying to compare. So if I, as an employee of a company or a government employee, I have access to Sun Life, well, if I want to go for services, I usually pay upfront depending on the service, but I usually pay upfront and then submit for reimbursement.

In the case of a veteran, I know in rehabilitation for sure, most of the services they would have to pay out-of-pocket upfront. It would be prearranged through the authorizations that we did where they could just show up for their treatment and payment would happen through Medavie. So the provider would bill Medavie, if that makes sense.

Q. Yeah. Direct billing.

A. Yeah.

Q. Can you talk a little bit about challenges you might face as a case manager?

A. Yeah. Well, from a sort of case manager/client perspective, challenges that you might face, as I mentioned before, some sort of preconceived notions about what VAC is like and what VAC offers or doesn't offer. So challenges in establishing trust sometimes with clients. And it often has nothing to do with you as necessarily a worker. So I can think of veterans who I worked with where, you know, it was difficult phone call after difficult phone call because there was sort of a general mistrust of you as a VAC case manager. So that's a challenge but, I mean, part of our role to deal with.

On an administrative level, I talked about the request coming from various directions. There's a lot of systems that you need to check for information and so ... yeah. So there's often ... a big challenge is figuring out what you need to prioritize when there's so much that you are expected to complete in terms of tasks and then also prioritizing. I know for myself, I was very much, you know, a veteran-first kind of person. So do I write these notes late so that I can actually make sure that this is in place or that the veteran has the

support? So negotiating that constantly, I would say, in my experience.

Other challenges, trying to think. It's been a little while. Yeah. It's the type of workload that never goes away. I'm sure some of you know a thing or two about that. So if you're getting ready to go on vacation even for a week, there's a lot of things that you're trying to make sure are in place and then when you come back, the pile has never gone down. It just sort of ... because, yes, we have intake services but they're there really just to deal with urgent matters. So ... yeah.

Q. And what sort of tools in your toolbox do you use to deal with maybe a veteran who's sort of overtly maybe expressing some anger or frustration with whatever?

A. Well, personally, I would say that my experience at the Correctional Services came in very handy that way in terms of being able to set a boundary. Because there's a difference between a veteran who may be upset or overwhelmed or angry versus someone who is blatantly name-calling and yelling at you. So depending on what that situation is, I mean we were ... we had some training on diffusing situations, de-escalating, that sort of stuff.

I guess my tools ... the tool that I ... when I needed to

refer to was just being clear about, okay, you know, expressing and validating that you hear the frustration or that, I'm only able to help you if the screaming stops or that sort of stuff. So it's communication a lot of non-violent communication skills and generally worked okay.

But, at the same time, I can think of many instances where a veteran may have been so upset that they just decided to end the call prematurely, This is too much for me today and ... so not taking those things personally is very important in our role, that it was okay that people are frustrated based on their experience or ... and then the next time we talk to them just ... you know, you try to re-engage, it's a new day, and build from where you left off. So, yeah. Trying to think what else in terms of tools.

Q. Well, let's talk a bit about the training that you received for your job as a case manager. Is there training specific to the job of a case manager that VAC provided to you?

A. Yeah. When I arrived at VAC in 2015, there was sort of a massive ... it felt like a very massive recruitment effort being done across the country. So when I came onboard, we had what was, I believe, called National Orientation Training Program, and I think ... I'm not a hundred percent sure but I'm

pretty sure that I was part of the first core of case managers in Veterans Affairs to actually complete the program from A to Z.

So, essentially, when we arrived, within ... I think it was our second week of employment, we were in classroom training for a whole week with fellow case managers who were recently hired. And the training, you know, had, you know ... there were so many things that were ... we were introduced to in training; you know, VAC policies and programs, eligibility criteria, that sort of thing, and then who is in VAC, like who are the subject-matter experts that we can consult. So, for example, when we had in-person training, there was an opportunity to meet with different professionals and they were able to explain to us, you know, their job and how they can support case management process.

And then in between ... in total, that was spread out over a year and a bit. We had three week-long, in-person trainings of that nature. And then, in between, modules that we could do ... that we were expected to complete by distance. Sometimes it was, you know, at your own pace; other times, it was we were all logging on at the same time, NDSU was providing a training on ... like one that comes to mind is veterans at risk of

homelessness or experiencing homelessness, how you work with that reality. So there were different themes, as well, that we explored in training.

(10:30)

Q. So you mentioned VAC policies, philosophy, risk of homelessness. What about addiction or substance abuse issues?

A. Yeah. There was some. There was some training on helping veterans who were experiencing substance misuse or abuse. And I don't remember sort of the length of that, but I do remember a module specifically on that topic.

Q. And we were talking earlier about maybe de-escalation tactics for dealing with difficult clients or diffusing situations. Is that something that was covered?

A. Yeah. Absolutely. There was at least one session that I can remember which really focussed on how you deal with an angry caller, for example, or how do you diffuse a situation like that, because there is a reality with ... I mean it's one thing to help people, but helping people over the phone is a very particular reality, so those themes were explored in training as well.

Q. I guess keeping in mind you're not a health care provider, did you have any training with respect to recognizing

a mental health emergency or crisis?

A. Yes. Like in terms of a mental health crisis, we were expected to stay, I guess, certified or fresh in our suicide intervention training and I think the training that I got, like I'd had some prior to VAC, but the training that I received specifically at VAC was "Assist" which is, I think, world-renowned through ... "LivingWorks" is the name of the host company. So we did do "Assist" training at Veterans Affairs which is about recognizing signs and situations where a veteran may be, or a person, may be suicidal. And then helping create a safety plan in the immediate for that person.

Q. And what else would you maybe do in that situation if you were faced with someone who is threatening self-harm?

A. Well, when you're faced with someone who is threatening self-harm it's, you know, important to go to the heart of the issue and be clear with terminology. So ask the question directly: Are you thinking about suicide? Are you thinking about killing yourself? And then, depending on the answers provided, then there's a series of actions that you would take from there. And you mentioned "analysis" before as part of our role of analyzing that risk in the moment.

So one of the things about suicide intervention is you're

with a person in the moment - it could be on the phone or in person - and you have the ability to help in that moment and create safety in the immediate. What happens five, seven, ten hours later, not generally within your control but ... yeah. So if ... depending on the answers that you get to the questions, then you may be required to contact emergency services. That's happened before, when I was on intake duties, where I've had to do that. And then my goal was always to keep the veteran on the phone with me and then enlist the help of a colleague so that we can make sure that they stay safe until emergency services has arrived. By no means an easy task, but, yeah, we are trained to deal with those situations.

Q. We've heard about a VAC assistance service. It's a 24/7, 1-800 line, but I'm taking that, in an emergency, that might not be the number that you would be calling.

A. I think it was called a "VAC assistance program" or "VAC assistance line". It's very similar to an employee assistance program, if you're familiar with those. So the idea is, yeah, you can call ... You know, if you're having a difficult night, you can call in the middle of the night and expect someone on the other end of the line to answer. And if there is an immediate need or urgent need, then there is someone

trained on the other end of the line to help you.

As a case manager, that's a resource that you would often give a client on intake, for example. It could be a client that I might end up speaking to only once. And you tell them, you know, If you ever experience a crisis - it could be also a member of your immediate family - this is a number that you can call. You know, there's VAC. You can call VAC and speak to a case manager but there's also this. And, sometimes, some people preferred to call VAC Assistance Service because it's very anonymous.

So, no. If I understand your question, if I had someone with me on the phone who was at immediate risk of self-harm, I wouldn't direct them to VAC Assistance Service. I would go to 9-1-1. Or if they're with someone, encourage them to go to their local emergency room. But VAC Assistance Service could come in handy, for example, if you had a client who experiences suicidal ideation. So we have people who struggle with suicidal ideation over years. So if it's a time where you're struggling and you need someone to talk you through that period, yeah, you could call VAC Assistance.

Q. And have you had any specific training about intimate partner violence?

A. Not at Veterans Affairs, no.

Q. If ... go ahead.

A. Some ... If I've done ... Any training that I've done in intimate partner violence would've been of my own choosing. Like gone to a conference or ... and a little bit when I was with the correctional service, given some of the specific clientele that I was expected to monitor on a regular basis.

Q. If you were on the phone with a veteran who was threatening or suggesting harm to others, how would you act? Like what would you do?

A. Well, in a similar way, when a person is threatening harm to others, that ... it's a known ... like we explain to our clients when we start working with them that there's limits to confidentiality. So if you're threatening to harm someone then confidentiality doesn't stand anymore. So it's my job to make sure that ... well, it's anyone's job to make sure that the proper help is received. So it would be, more than likely, a call to emergency services.

Also, if we know who the threats are directed at, then doing our best to make sure that this person or these people are informed so they can keep themselves safe. It's not something

that's happened often in the course of my work at VAC. So ... but I would, you know, certainly take that very seriously and be transparent as much as possible with the veteran about what I need to do.

Q. Just to talk a little bit more about the "on the ground" situation when you were case manager in 2015 to 2018 - pre-COVID. Could veterans access the actual physical office where you located?

A. Yes, absolutely. We call them "area offices" and they're, I think, in every, you know, major Canadian city and near the CFB, like the Canadian Force bases. And many clients would, you know, drop in. It could be to ... they'd rather deliver a form or something in person or they're looking for information and, you know, it's in their city, so they prefer to come in. And we have people who are responsible to greet and, you know, work at reception.

So when we're on intake duties, for example, we take a lot of calls, but we sometimes have walk-in clients as well. So someone might come in with "x" issue and then the reception personnel would come find the intake case manager and say, We don't really know what we can do in this situation. Can you help? And then we could meet the person face-to-face.

(10:40)

Q. And where were you physically located and did that change for you?

A. Yes. So in 2015, when I was hired, it was very ... it was made clear to myself and a group of other people who were hired ... I was living in Fredericton at the time and there was like a temporary office on base in Oromocto, which is nearby, if you are familiar with New Brunswick geography. So when we were hired, it was made clear from the beginning that the plans were to eventually have us in the Oromocto/Gagetown office. However, there wasn't a space that could hold everybody at the moment, so we were travelling to Saint John, New Brunswick, in the southern part of New Brunswick, where there was a larger office and space that could accommodate the new hires. Like I said, they were hiring a number of people at once, so I and three other colleagues travelled from Fredericton to Saint John for ten months to a year maybe, until a space - and it turned out to be a temporary space - was available downtown Fredericton. I was there for a little bit. Eventually transferred to another province but I think, today, the office has, you know, permanently moved to Oromocto because it is closer to Base Gagetown.

Q. Just to, I guess, kind of solidify in our minds how someone accesses case management services, we did hear evidence from Mr. Marshall, but the logistics of actually accessing a case manager, do you call a 1-800 number? Do you call someone directly? How does that work?

A. If you're not case managed, generally, yes, you're calling the 1-800 number that takes you to our NCCN, so it's National Contact Centre Network or something like that. And you're always guaranteed between, like during office hours, that someone is answering the phones. So if you're calling specifically saying, I want to be case managed, or you're calling with a question that the other frontline agents ... So it might go to a veteran service agent first, for example, and then if they determine that it's more a case-management issue or question, then transfer them to us. And then there's a bit of an assessment to determine, okay, do we ... is this situation appropriate for case management?

Without going too deep into this, there's case management and then there's case management within the rehabilitation program. So most of the veterans that we worked with in case management were in the rehabilitation program, but there were a select few. Like I've case-managed veterans outside of the

rehabilitation program because of a significant illness. For example, I had a few clients who were diagnosed and, unfortunately, have since passed, of ALS. So they required a lot of support in the home, and the caregivers as well. So that would be an example of, you know, case managing where the objective is not rehabilitation, but just helping them manage a complex situation.

So, yeah, I think calling is probably the most common way to connect to case management services. I mean there's a website you can go get all kinds of information that's available to the public, and you could drop into an area office. Chances are, you're not assigned a case manager at that moment on that day but, you know, you may initiate contact with VAC that way as well.

Q. So if I am assigned a case manager and I call the 1-800 number, I can say, My case manager is Ms. Doucette, can you connect me to her? Is that something you can do?

A. Yeah, absolutely. When there are case management, there's actually ... when they're a case-managed clients there's actually like a ... it's identified on their file and there's a code assigned to us. I was CM-28, for example. So the analyst who answers the phone can easily see. So it's just a matter of,

Could I speak to my case manager, Ms. Doucette? And they'll transfer you through. Sometimes they're calling about things that are not really case-management relevant, so the analyst can help direct the call to the appropriate person as well.

Q. And just to talk a little bit more about the CSDN - client service delivery network. And we did hear some about that from Mr. Marshall, but does everyone who has access to CSDN have access to everything that would be in that network?

A. No. I guess the simplest way that I could describe CSDN, it would be like the equivalent of a giant paper file that we used to have, you know, back in the '80s/'90s. So everything goes into CSDN of the veteran's personal information. So address, next-of-kin, all that information. It's where we do the client screenings you've talked about. So there's embedded tools. Our case plan tool was embedded there at the time. I think it has since changed, but it was in CSDN when I worked there.

So, as a case manager, I certainly had access to a number of things within CSDN but, I, like all other employees, consulted sections on a "need-to-know" basis. So there's things on the veteran's file that I wasn't privy to that information because it didn't have any sort of bearing on the work that we

did together. I'm thinking of ... What would often happen is a client may call and say, I want to be transferred to my case manager, please. And then they would put them through. And then we're talking about rehabilitation, but then they're also concerned about an adjudication matter or a disability award, which we have no sort of power or decision-making authority in that. So sometimes a veteran could ask, Would you be willing to check and see where the decision is at? So if they ask you to do that, that's a small thing that you could do as a case manager is just check and see if ... Oh, well it says on such date that you're ... But you don't see like necessarily all the details of their application and all that. You can tell them about progress but ... yeah. That would be an example of adjudication matters. And the medical reports related to that, I, as a case manager, had no need to access.

Q. So you needed some sort of basis to access information.

A. Yeah. And you need to be able to justify it. I mean it's the basis of confidentiality and privacy. So you may see on someone's file ... For example, if I was an intake case manager and I get a call from a client who is not assigned to me, then I would specify like, "Client's file accessed as part

of case management duties" because it has to be clear. Like I can't just go in other people's files just because I want to. Even though the system would allow me to do it, I'm expected to respect that boundary.

Q. And you would make a record in the system that, you know, you accessed this for this purpose.

A. Yeah, absolutely.

Q. So you mentioned a little bit about this before, but if you're going on vacation, what's the plan that, maybe if you didn't mention any, if there's additional details that you didn't mention.

A. Yeah. Well, in my experience, I generally took, you know, a week at a time. Like I was not often gone for a lengthy period. So if I had veterans who were, you know, on my caseload who were struggling particularly at that time, I'd try to make sure that they're aware that I'll be away and that these are resources that you can access while I'm away.

So, you know, there's a lot of ... I guess there's a lot of education also in our role where we have to explain what the intake case manager does and doesn't do. And VAC Assistance Service, for example. And then, you know, remind them of their providers who are, you know, supporting them in the community as

well. So you can't do that for every client because you'll never go on vacation. But I guess my approach would've been, if I have a few clients who are waiting for a call from me, I try to touch base with them before I go, and then ... But you do have a bit of peace of mind knowing that if there was an urgent situation, you have a colleague that is there to sort of offer support in the immediate. And then what else? Vacation. Yeah. I guess you try to just, you know, tie up loose ends as much as you can, and when you come back, you pick up with where you left off and a bunch of surprises based on what happened while you were away.

(10:50)

Q. Yeah. That's a struggle that a lot of people have when they go on vacation.

A. Yes.

Q. So the CSDN network, you kind of talked about it like ... you know, if we're kind of visualizing it as a paper file and you're putting in information on case planning. There are embedded tools we talked about. Would this system have every single detail of every interaction you have with a veteran?

A. No. I don't think that would be humanly possible. I mean it's our responsibility and, you know, we do our very best

to try to document every interaction, but sometimes you could have a client who has called you multiple times in a day and so you provide a summary of the conversations. Or sometimes ... I'm trying to think of an example. Maybe a veteran is asking for something that is outside of the rehabilitation program, so I'd connect them to a colleague. The colleague may be the one inputting the note about that. You know what I mean? So I don't think it would be realistic to say that every detail gets captured. And some details are not necessarily relevant, you know. If we talk about ... you know, the veteran tells you about their new dog that they recently ... You know what I mean? Because you get to know these people, so there's a lot of conversation that happens and you try to, you know, stick to the details that are relevant to progress.

Q. And just thinking back to, you were talking about sort of a day in the life. If you're travelling, would there be situations while you're driving a vehicle to somebody's house, you're not able to, you know, note-take, so some of that may be later on in the day?

A. Yeah. Or in the week or ... it's happened. Things have slipped my mind. I can really only speak for myself, personally. Our note-taking all happens on a computer. So we

would have ... we have a small laptop that we can carry with us but, where I can speak for myself, I had a caseload that was really spread out. So I worked from the Saint John office, but I had clients ... We have an office in the Campbellton, New Brunswick area which is like one of the most northern points. And they had an influx of clients and they needed bilingual case managers to support, so I was assigned clients who were, you know, a four-hour drive away from my office or my home. So when things got really busy, yeah, it would happen, I might take a call on Bluetooth from a provider or, you know, do a follow-up and whatnot, and I'm not sitting in front of my computer. So try your best to handwrite and come back to it, you know, and put it in the system when you can.

But, yeah, I can think of times where I've taken calls sitting in my car, parked somewhere, because there was a matter that needed attending to, even though I was on the road to see someone else, you know.

Q. Can you give us a sense of, you know, you're trying to understand this CSDN system, and if it's a computer system, are there things that are sort of system generated or auto generated and maybe if you could talk a little bit about that? Maybe like a work item, for example.

A. Yeah. Work items are basically a list of reminders for things that you have to do. I think all staff in Veterans Affairs have ... well, most staff who work with clients have sort of a running list of work items. Some are system generated, so they'd tell you if there is a case plan objective that is expired. For example, it might calculate ... If you were working with a veteran, it might calculate, oh, the veteran's ... Contact with this veteran is due within ... if you haven't had a documented contact with them in however much time. And then there's ... the VSTMs would generate work items for us. So anytime someone is assigned to you, that creates a work item. If someone changes address, that creates a work item. So there's an ongoing list of these. A colleague, the NCCN analyst, can create a work item. And then they get assigned to you based on your role and who your clients are.

Q. Can we talk a little bit about your caseload and starting ... You know, maybe talk about the caseload that you had when you started and whether that changed over time the time that you were there.

A. Yeah.

THE COURT: Sorry. Ms. Grant?

MS. GRANT: Mm-hmm.

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

MS. GRANT: Okay.

THE COURT: So if you can find a convenient place ...

MS. GRANT Yeah.

THE COURT: I know you just asked a question. We're kind of moving into a different area. It's almost 11:00, so I would look at taking a mid-morning break soon. We've been here for an ...

MS. GRANT: We can do it now.

THE COURT: ... hour/an hour and a half.

MS. GRANT: We can do it now.

THE COURT: Is this a good spot? All right. So, Ms. Doucette, we're going to take a break. It's ...

A. Okay.

THE COURT: It's just coming on 11:00. And so we'll take ... I know 15 minutes makes it short to do much, so I'll give another five. We'll make it 20 minutes. Okay?

A. Thank you.

THE COURT: We'll come back at 20 after 11 our time. Thank you.

COURT RECESSED (10:57 HRS.)

COURT RESUMED (11:21 HRS.)

THE COURT: Ms. Grant?

MS. GRANT: Thank you, Your Honour.

Hi. Can you hear me and see me okay?

A. Yes. Thank you.

Q. Quick sound check.

A. How about you?

Q. Yeah. Thanks.

A. Okay.

Q. So we're just going to talk about your caseload and what you started with and whether or not that was consistent over time or changed.

A. Okay. So, like I mentioned before, I arrived in September 2015 and I believe by October/November, I was given my first set of clients, if I can put it that way. I can't remember the exact number. Around six. And Mr. Desmond was actually part of that first group of clients that I inherited. And then from then on, I guess the initial delay was just some ... a lot of the training that we had to get done. And from that moment on, then we accrued clients every few weeks or so. Sometimes we might get assigned three new clients at once. And then it grew. The caseload grew that way pretty consistently.

So as a new case manager that was coming on board,

naturally, I had a smaller caseload at that time than someone who had been there for a number of years, but within a year's time, I had definitely somewhere between 35 and 40 clients. Something of that nature.

Q. And what was the aim for sort of a case manager to veteran ratio?

A. We were always told from the beginning that VAC's aim was 25 veterans to one case manager. Unfortunately, that's not something that I've experienced. And, I mean, I understand that there was a shortage of resources when I arrived; therefore, probably more veterans in need of services than resources that could be provided at the time.

Q. And what was your caseload around in January 2017?

A. I want to say between 35 and 40. I don't have the exact number for you, but I think that would be pretty accurate.

Q. Can you talk a little bit about ... so caseload is one of those things where I'm guessing you could have ... you know, one case manager could have maybe 25 people that don't call that often, but another person could have 25 people that call every day. So how does that work in terms of managing your caseload?

A. That's a constant, I don't want to call it a battle because it's not the appropriate word, but I guess it's a

constant challenge that we need to manage, is that, because of a larger caseload ... I think all of us probably have, you know, a handful of clients who call regularly, and some call very often. And then you have some clients that you're the one who has to initiate contact more. The challenge is when you have even three, four, or five clients who call very often, it sort of monopolizes a lot of the time that you have to give to (French phrase), like your entire caseload.

So there was ... I talked about, you know, identifying priorities before. It was sort of a constant negotiating of, Okay, well is this really urgent or is the person just ... is that their regular sort of beat that they call often. It's just the way that they sort of do business with us, if you want.

So, yeah. I mean, obviously, every caseload is different, but there's always going to be a certain number of clients that you work with more intensity because of their reality, and then some who aren't happy ... well, not happy, but content to hear from you on a regular basis, but more, you know, spread out.

The expectation, as far as I remember, was a minimum one contact with a client per 90 days. In many cases, it exceeded that, but that was sort of the ... that's what I remember being sort of the aim.

Q. And what about travel? Did your job involve a fair amount of travel?

A. Yeah. I think more office days for sure. I'd say, on average, probably four days out of a month, I could be on the road. And, again, it really depends on the geography of your caseload. Some people could have a very concentrated caseload, like in the Oromocto area, for example, because of the location of the base which is one of the bigger ones, I believe, in the country. There were a lot of clients near that base, so if your caseload was sort of concentrated in the Oromocto/Fredericton area, maybe you could reach more clients in a day. My caseload was pretty spread out. I had clients all along the Acadian coastline, up north, and some in the Fredericton/Oromocto area as well.

Q. And were you assigned ... You're bilingual. Correct?

A. Yes. French is my first language.

Q. So you had clients that were assigned on that basis as well?

A. Yes. So the Moncton area, naturally, and Acadian coastline had a lot more of our francophone clients. So I, yeah, travelled a bit.

Q. So is it fair to say some of your clients required

more of your time than others?

A. Yes.

Q. And were there ways to try to manage that with people who would call frequently?

A. Yeah. I mean I can think of one example that stands out for me where a veteran would call pretty much daily. And, you know, he may be speaking to someone else and then he would eventually, you know, be transferred back to me as I was the case manager. So sometimes there was just a bit of a coaching that we needed to do around, you know, It's okay if you need to touch base regularly. But, a lot of times, you know, if a veteran was calling daily, where just sort of not that much changes in a daytime, so a little bit of coaching as to, Well, maybe what we can do is set a scheduled time where we're going to chat, you know, once a week, and you can just get all your questions ready and ... So a little bit of that. I'd say the majority did not call that frequently, but it took only a few to really create a lot more demand, I guess.

(11:30)

Q. Before we move on to getting into your interactions with Mr. Desmond, we talked about sort of the general framework, your work as a case manager, and case managers generally. Is

there anything you thought of during the break that like, Oh, I meant to say I did, you know, such and such or ... I just wanted to give you an opportunity to think about that.

A. Oh! Not really. Took a break. Sorry.

Q. That's okay. We don't have to ...

A. Yeah. I will keep the question in mind though.

Q. Okay.

A. Because I'm sure ... I want to be clear that I haven't been at Veterans Affairs since January 2018. So, obviously, there are some aspects of the job that I'm probably not capturing as well as someone who would still be in the position so ...

Q. It's okay. So just ... we're going to turn now to your interactions and, in addition, your sort of VAC writ large interactions with Mr. Desmond. And I guess before we get into that, Mr. Desmond had sort of interactions with VAC that predated your involvement. So I just kind of want to go through those in a brief fashion so we kind of know where we're at when you enter as case manager.

And these are reflected in some of the documents we talked about, the client screening document and the transition interview, things like that. So ... and you can just say if

you're aware or not of this ... kind of the individual items that I'm going to go through. That Mr. Desmond had a disability decision for post-traumatic stress disorder?

A. Yes, I was aware.

Q. And in May 25th, 2015 there was a transition interview with a VAC client service agent?

A. It's pretty standard procedure so, yeah, that makes sense.

Q. And there had been ...

THE COURT: Sorry, Ms. Grant. I'm going to stop you ...

MS. GRANT: Oh, sorry.

THE COURT: ... for a second. So if you're referring to a particular exhibit and if there's a particular page or an area that you can reference when you ask the question ... I don't know if you're set up that way, but if you have that ability to reference something that's in a document that, for instance, Ms. Doucette may have read and informed herself about and it comes from a document, not from her personal knowledge or recollection or refreshment, then if you could direct us to where that is that would be helpful.

MS. GRANT: Thank you, Your Honour. I do have that for most of Ms. Doucette's personal interactions. This was sort of

just, you know, trying to set up where we were. So I don't have all of the references, but Exhibit 273, the client screenings document, is the main source of this list.

THE COURT: Okay. Thank you.

MS. GRANT: So it's your understanding that Mr. Desmond had been referred to an OSI clinic before you were assigned as case manager?

A. Yeah. When he was assigned, that was information that was made available at that time.

Q. And it's your understanding that Mr. Desmond had been medically released from the Canadian Armed Forces?

A. Yeah.

Q. And it's your understanding that Mr. Desmond was granted access to the rehabilitation program for his PTSD?

A. Yes.

Q. And that rehabilitation program, what are the general components of that?

A. Well, it starts with the decision being rendered and then assignment to a case manager. You can't do the rehabilitation program without assignment to a case manager. And it goes back to what I mentioned earlier. So the area counsellor assessment we did, then building that case plan. And

the case plan is sort of the tool through which we're able to authorize. We identify goals, we authorize services, monitor progress. So there's progress notes within the case plan as well.

And then there is not necessarily a prescribed expiry date to the rehabilitation program, but as we progress evidence is collected as to the veteran's progress in rehabilitation. Are they meeting most, some of their objectives, or none whatsoever? And, in time, we work towards disengagement but that's very general.

Q. Yeah.

A. But ... yeah.

Q. And your understanding would be that he was also then eligible for earnings loss benefit?

A. Yes. Yeah. Earnings loss benefit at the time was tied to a rehabilitation program. So if you were eligible to the program ... the way I recall it is you could apply for earnings loss benefit and then depending where you were in your transition. So we had some people coming into the rehabilitation program ten years after they were released from the Forces, but many coming into rehab program within months or the first few years of their release.

And when they're within the first few years of their release, they usually had another form of earnings loss through Manulife. I believe SISIP is what it was called. So that usually lasted somewhere around two years. So they wouldn't receive both but they were covered under one or the other. And if they were still on rehabilitation with VAC when their SISIP funding ended then they could transfer into earnings loss benefit.

Q. The next references are all from Exhibit 273. This one is page 19. In August 31st, 2015, Mr. Desmond came into the CFB Gagetown office to check on the status of his claim and received clarification on letters he received. Is that your understanding?

EXHIBIT P-000273 - CLIENT'S NOTES (CSDN)

A. Yes. I would not have been made aware of that at the time because he was not assigned to me, but having worked with Mr. Desmond afterwards, I know that he didn't hesitate to go to the CFB Gagetown office if he needed to hand over documents or obtain documents or check on status of things.

Q. And there was a treatment authorization centre authorization received for medical marijuana? Sorry. On page 18. Your understanding when you joined the case, Mr. Desmond

had been approved for medical marijuana.

A. Yes.

Q. And then page 17 of the same exhibit, there's a note that a social worker, Zandra Pinette contacted the authorization centre to provide services to Mr. Desmond. I believe that was from the VAC assistance program. Is that your understanding, as well?

A. I am not sure if it was from the VAC assistance program. It was definitely outside the rehabilitation program.

Q. Okay. Thanks. So now we're going to turn to your interactions and how you became involved with Mr. Desmond. I understand you interacted with him on a first-name basis. He called you Marie, you called him Lionel.

A. Yeah. He often made the effort to pronounce my name in French. He would say ... call me MAH-ree.

Q. So, throughout, I know you knew Mr. Desmond personally. So I just wanted to make that point. So our understanding from the evidence is that there was a transition interview on May 25th and there was a work item generated. And that's Exhibit 290.

EXHIBIT P-000290 - COMPLETE CLIENT SCREENINGS CSDN LD

And it looks like that work item was sent to an office to

request a case manager assessment. So can you talk about how you actually got assigned and that process?

A. I'm going to look to the other screen because it's bigger on there.

Q. Sure. Yeah.

A. So my recollection of work items such as this one is that it was generated and then if you look under top right-hand where it says, "completed 2015-11-26", so that means that I would have received the work item, he's been assigned to me, and I went in the system and completed the work item. So I don't believe it would have come to me as early as ... well, I wasn't there in May, but ... yeah. When you see the difference in the date, that's how I can explain that.

(11:40)

And, yeah, so any time a new client is assigned to us, we will have ... like the veteran service team manager will actually come to our desk and hand over a piece of paper or like a slim file of sorts to say, Okay, these are the new clients. But a work item is generated, yes, when we're assigned a new client.

Q. So you talked earlier about how you were hired and you had training. So when did you actually ... and I think you also

mentioned that Mr. Desmond was in your first cohort of file assignments. Is that right?

A. Yeah.

Q. Okay. So do you have kind of any information about the length of time between May and November and why that assignment or work item took from May to November to generate or be actioned?

A. I obviously don't have the department reason for that. My understanding would have to do with resources and then priority assignment cases. So, like I said, when I was hired there was, I believe, six or seven just in the New Brunswick office that were hired at the same time to make up for ... I understand that there had been some cuts under a previous government and then they were trying to rehire a number of case managers to assist with the demand.

So, like I said, when I arrived there were six or seven. And in just my first year and such we also had a few retirements. So there definitely seemed to be more demand coming in, so veterans, for example, eligible for case management than there were case managers to assign to. And when I arrived in September, training was the focus at least for the first four to five weeks and then assignment slowly started. So

that's how I could explain it. But I don't obviously have the official explanation.

Q. And when you were assigned, Mr. Desmond was already under the care of the New Brunswick OSI clinic team.

A. Yes.

Q. Okay. And so you weren't involved in the referral process on that.

A. No. It does happen with veterans who are medically releasing from the Forces. They would have a case manager ... I think nurse case manager, if I'm not mistaken, with the CAF. And then as they're transferring out or before they transfer out, it is possible for that case manager to refer to OSI. So in Mr. Desmond's case, I can safely assume that that's what happened. So that when I arrived, he had already been engaging with a few of the treatment providers at the OSI clinic in Fredericton.

Q. And the client notes from CSDN, Exhibit 273, it's a bit of a dense document, so I don't ... and we can go there if you want to, but I'm just sort of noting the references for the record. It goes backward when you print it off, so it's a little bit hard to read.

Your first entry in the plan notes indicates that a call

came from in from Dr. Murgatroyd, and we have heard evidence from Dr. Murgatroyd, on November 19, 2015. And our understanding from that note is that he had expressed some concerns with Mr. Desmond's instability and need for coordinated support. And you noted the doctor's opinion about immediate risks and needs and that Mr. Desmond was willing to do some therapeutic work with Dr. Murgatroyd for PTSD once he had reached a more stable state. So that first interaction with Dr. Murgatroyd, is there anything else that you can recall about that?

A. Is it okay if I simply read the note?

Q. Of course.

THE COURT: Ms. Doucette, what I would say to you, as well, is that if any of the lawyers ask you questions about a document and if it is more helpful to you to be able to actually read the entry or the document, please just ask. We have all the documents that are available.

MS. DOUCETTE: Okay.

THE COURT: We can put them up on the screen for you and then you can refresh your memory before you venture to ask the question, if that's of assistance to you. Okay?

MS. DOUCETTE: Thank you. I appreciate that.

THE COURT: Thank you.

MS. DOUCETTE: Yes. So I guess what I recall from that interaction is I've been assigned a case. I'm having to familiarize with Mr. Desmond and a few other veterans' cases at the same time. And Dr. Murgatroyd, who is already familiar with Mr. Desmond, initiates contact.

And, you know, the understanding is we're attempting to do some trauma work, specific trauma therapy with him. And that's not working so well because of a certain instability, whether it be emotional and he was also sort of living in between two places at the same time. So already they had recommendations for needing more support.

So this was sort of confirmation that, yes, I'm assigned to the case; you know, thank you for submitting this information and I am going to be in touch with the veteran as soon as I can. He referenced, "Obtain doctor's opinions re immediate risk and needs." I don't go into any details about that. Had there been a significant risk at that time, then that's something that we would have acted on and more detail necessarily provided.

MS. GRANT: So at that point when you're familiarizing yourself with the file, what was your priority?

A. Well, priority is sort of getting a quick sort of

picture of the person's situation and then establishing contact and establishing contact so that a time can be set up to fit and meet and, like I said before, when we're doing the initial assessment, actually take the time to do that. So if for one veteran it's going to take a few hours, then we'll take the few hours because we know that from there on a lot of the work that we're going to be doing with him is going to be over the phone. So this is really an opportunity to connect and get to know them a little bit better.

So, yeah, I would say from there having the doctor call and introduce himself and whatnot would have been like, Okay, so maybe this is something I can prioritize as contacting this veteran right away. When you're getting familiar with other cases, so it gives you a sense of, Okay, well, who can I ... who might I talk to first? Maybe another person didn't have a doctor calling or saying, We think he could use more coordinated support now.

Q. Right. And just for your reference, that's Exhibit 273, page 17. What steps did you take with respect to ... you know, we talked about the national contact centre. Did you do anything there?

A. Can you ... sorry. Can you repeat that?

Q. Yeah. We talked earlier about when a veteran calls the client ... or the contact centre, if they know who the case manager is they can direct them.

A. Yes.

Q. So I think this note reflects that you contacted the NCCN to indicate that you're the case manager that's assigned now.

A. Yeah. So from reviewing my very initial notes or interactions with Lionel Desmond, I remember trying to reach him and not being able to. I believe I left a message and then perhaps called another time and couldn't leave a message. So I just wanted to make sure that if he was calling in to Veterans Affairs that the NCCN was aware that I was trying to reach him. So I believe that's probably what you're referring to.

(11:50)

And I think Dr. Murgatroyd actually became sort of instrumental in establishing contact when the efforts that were made ... like we weren't ... I wasn't able to establish contact with him right away, so because I knew Dr. Murgatroyd was working closely in the case, I was also able to let him know, Listen, when you see the veteran, let him know that I'm trying to get a hold of him.

Q. And the next note is for the 27th of November 2015. And that's the client screening document, Exhibit 292, and the client notes, Exhibit 273, page 16. It looks like that Lionel Desmond called that number and was transferred to you. Can you talk a little bit about that conversation?

A. Yeah. Is it possible to ...

Q. For sure.

A. Do I have that note in front of me?

Q. Yeah. Exhibit 273. I think it's page 16.

THE COURT: And I take it it's an entry with regard to November the 27th. And the time ... the particular time entry ...

MS. DOUCETTE: Okay.

MS. GRANT: November the 27. Yes.

THE COURT: Okay.

MS. DOUCETTE: Okay. So where it says, "Client screening completed. Refer to screening tool." Yeah. So client screening, we didn't have a case plan or a rehabilitation plan open yet because he was a new client. So the common practice is when you receive a call from a client, then you're going to do a screening, which is another sort of ... like one of those embedded tools that I talked to you about in CSDN. That's where

you document basically the summary of the call, but there's a few items that you check in with the veteran on.

Case managers are not the only people who do client screenings. I believe our VSAs and analysts do them as well. So I don't remember the exact detail of that screening but the screening would have happened as a standard sort of procedure when he called.

MS. GRANT: Do you remember what you talked about?

A. I'm sort of ... I'm guessing that that's when I would have tried to establish a time to meet with him but I may be mistaken.

Q. Do you recall anything about his family ... talking about his family circumstances?

A. On that specific day? It's possible, but I don't ... that's not that clear in my memory. Sorry.

Q. Okay. What else ... do you recall anything else sort of in those initial stages in November?

A. November, specifically? November/December is a bit of a ... I may be mixing up some dates, but I know that we set up the first appointment to meet in December. And so that first appointment would have been the start of the area counsellor assessment. I know that there's a time when he had disclosed an

intervention from the police, but I can't remember for sure if it was around that time.

Q. I'm going to bring you to ...

A. But I feel like it was pretty early into the relationship with me. Yeah.

EXHIBIT P-000292 - CLIENT INITIATED SCREENINGS (CSDN)

Q. I was trying to find the document myself. Exhibit 292, which is the client screening document. And it's on actual page nine, even though these pages are not numbered.

A. Perfect.

Q. And it's towards the bottom of that page, just to maybe help you refresh your memory. If you want to take a minute to read that.

A. Sure. Thank you. Okay. So he had ... like the screening happened because he was returning my call. Describing his living situation. He was describing a difficult situation, so I quickly assessed any risk of suicide. He assured he wasn't thinking about any of that. There was the VAC assistance service. Like I said, I often would present that to clients in case they are having a difficult day. It could be on a weekend, it could be in the evening, or they're trying to ... whatever reason, they don't feel like getting through to VAC. This is

another resource. So I would have explained the resource to him.

And it's pretty typical, as well, for us to let our clients know that if there's a change in their situation, in their health, in their status, to contact us and to let us know so that we can ... because there ... time passes between the time that we're talking to them and we're not always aware of the important changes.

Q. And I guess just a point, that number, is that a number that family members can also use or is it just for veterans?

A. Yes. Immediate family. So essentially the people who live under the same roof as you, so spouse, children. I think it's stepchildren, that sort of reality as well.

Q. Okay. I want to turn to December 2015 and what you were doing as case manager on this particular file and, you know, working towards an initial meeting.

A. Yes. So as per the screening we just looked at, we set a date to meet. So that means that I would have traveled to his home in Oromocto because that was his main address at the time. I was aware that, like he explained, he would travel to Nova Scotia to visit with his wife and daughter from time to

time or fairly regularly, but that his main address remained in Oromocto. So that's where we met.

And when I reviewed my notes, what I can recall from that is that the assessment process took place over two visits. So I remember reading "short visit", so I think the first one that we had in December was a bit shorter so we agreed that we would have a follow-up visit to complete the assessment and start working on the plan.

So December would have been the first in-person contact and when I'm actually learning more about his situation. And when we do the assessment, we touch on many aspects of their lives. It's a pretty complete assessment ... or global, if you want.

Q. The first time that you went to Mr. Desmond's home, was he home? Was he at home?

A. There was a time that I showed up at his house and he wasn't there. And I don't remember if it was the first time or the follow-up visit. And we had a scheduled visit. I showed up, rang the doorbell, no answer. So I guess probably didn't have his number handy because I called in the office and had a colleague who was on intake just verify that for me.

And I contacted him and I remember him telling me he was out of province to attend a funeral. So there had been a death

in ... I don't know if it was his family or wife's family, but had just sort of forgotten to let me know that that had happened. So, understandably, that was his priority. So then we scheduled the follow-up visit for another day. And I think I was a bit more careful of checking and making sure he was going to be at home the next time.

Q. So on the first time that you met, what do you recall about that interaction?

(12:00)

A. I remember a very friendly ... he had a clean home. It was ... you talked about that earlier, the medicinal marijuana. That was evident that that was ... he was using that. And I remember he wore sort of a brace around his ... like a ... it was sort of like a large belt. And he talked a lot about chronic back pain, which is why he wore that. So that's pretty clear in my memory.

You know, he seemed happy to be engaging. There was no ... I didn't get a sense that he was mistrusting of me being there or anything like that. And, obviously, I ask a lot of questions, because that's the assessment process, and he participated, he engaged.

Q. I want to talk a little bit more about the assessment

but before we get to that, on the client's screening exhibit, which is 292, page six, I think. If you could talk a little bit more about this note and please feel free to review it. Your understanding of an incident that occurred with the police.

A. Sure. The note is not up yet but I have a pretty good idea. Yeah, it's information that he offered as like we were talking. Explained that the police had been to his home and the context of that. So, obviously, took the time to hear his story and then reassess. Like how he is doing today. Is there, are there any thoughts of suicide, is there history of this, and he was adamant that there wasn't and that at the time his wife had sort of interpreted the way he was saying good-bye to me that he was at risk. But he was open, however, that he wasn't doing the best emotionally. So that's when, in my role, I asked, okay, when are you meeting with, you know, your mental health supports again, and that was that same week. And, again, he's aware that he is recommending inpatient treatment at this point so he's already talking about it. And we were going to have like regular follow-up meeting that same week as well.

And then I see here the mobile crisis is a provincial, I don't know if you have the equivalent in Nova Scotia, but we have mobile crisis units. So, basically, what I did in that

call, other than confirm, okay, well, what do you have coming up to support you, you know, ask the questions that I'm expected to ask. If there is a possibility that someone may be thinking of suicide, the VAC-assistance number I had already given him, so a reminder of that. And then explained to him what mobile crisis is. You know, even though he was saying that wasn't the case, I wasn't really suicidal. It's sort of a better safe than sorry, here are the resources that are available to you at any time of day.

Q. Okay, when you did conduct what was then known as the AC assessment, maybe we could go to that document, Exhibit 291, and you can review, if you need to. I think, generally, it's a bit of a ... It looks like a document that you maybe completed some on ... within the CSDN, you know, or there's parts where you can check boxes and there's part where you can elucidate on stuff.

A. Yeah.

EXHIBIT P-000291 - AREA COUNSELLOR CLIENT-CENTERED ASSESSMENT

Q. If you could kind of give us, you know, what was your overall kind of assessment and, you know, what were the things that really stood out to you?

A. Well, if you scroll down a little bit, you will see there's a place where we talk about general health. So this is where the assessment always has us asking the veteran their perception of how they're doing health-wise. And then we have the responsibility to also sort of use our judgement and, based on the questions that we ask. So whatever is captured here in general health, it would have been an opportunity for ... I would have given the veteran an opportunity to really talk about any sort of illness or ache or pain, like anything medical that he was struggling with. So just not to sidetrack but when a veteran is admitted to the rehabilitation program, it's based on civic conditions. So, in Mr. Desmond's case, he was eligible for the rehabilitation program because of his PTSD diagnosis now. We know that sometimes, you can call it co-morbidities or there's, you know, your physical health can be impacted by your psychological health and vice versa. So we do take the time to still assess for anything else. So back pain was something that he talked a lot about. And I believe I informed him at that time that he could, if he thought that the back injury could be attributed to service and that as it existed, or he could get assessed by a physician and obtain that evidence, that we might be able to consider that condition as well for treatment through

the rehabilitation program. So we do a general health and then there's a section specific on mental health. And then we touch on everything from the ability where you talk about finances, family relationships, the ability for the veteran's independence in terms of taking care of themselves. Keep in mind that this assessment document, I believe, has been changed and was in the process of changing when I was at VAC, because a lot of it had been geared towards a more elderly veteran. So we were assessing further ability to live independently and whatnot. So, in general, there was the benefit of already having psychologists and psychiatrists engaged with the veteran. So we were able to discuss his mental health, his perceived challenges, and then we also ... It's not always the case but we had sort of the advantage of already having some evidence to refer to and some recommendations, I should say, from the treating psychologist. So from the moment of the assessment, we were able to discuss, well, how he felt about the recommendations that Dr. Murgatroyd and Dr. Njoku at the OSI clinic were making, which was stabilization and treatment, stabilization program at Ste. Anne's.

And he talked about, well, we talked, like you see there's a section on his moods. So he has an ability to talk about or a

chance to talk about any emotions that he particularly struggles with and how he feels he's doing in terms of cognition.

Q. In terms of breaking it down maybe a little bit in terms of the physical, mental, psychosocial, you know, what were the main physical issues? You mentioned back pain.

(12:10)

A. Back pain was ... he talked about it quite a bit because it was the one sort of medical or physical injury that was limiting to him. I remember he talked about how he used to do track and field or he enjoyed running and the back pain, you know, did not allow him to do that anymore. So he felt probably more limited by this injury. So it makes sense that he would talk about that. And in terms of, here we have on the screen like the mental functioning. So it was very common for ... like we would seldom have nothing checked off here when we're doing an assessment with a veteran because, you know, it could be either a result of a psychological condition or chronic pain or whatnot but they would talk about like concentration being impacted or ... I checked off comprehension here. I do recall Mr. Desmond being engaged but sometimes you had to reword questions just to validate that he understood. And I'm trying to think what else. So there's talk about his supports. So

one of the things when we meet with a veteran for the first time, they're always invited to have a family member present or, you know, a personal support present, if they wish to do so. In his case, we met just me with him, which is not out of the ordinary. I've had, you know, a number of veterans with whom I've met alone. And then we talked about supports and, you know, how that could be helpful in their rehabilitation program. When I asked about who his main support would be, he mentioned his wife, who was next-of-kin, would be but that he didn't feel that that was working at the time, that the communication was not good and he felt like he needed more support from professionals at this time, seemed to be what he prioritized.

Q. Did he mention his house being for sale at that time?

A. Yes, so from the moment I met with him, he made it clear that his intention was to eventually leave Oromocto. He talked about struggling a little bit with living so close to the base and not necessarily the people but just the constant remainders of the military community around him and living apart from his family was something that he seemed to be preoccupied with. Like he would have preferred to be altogether in one place but that was difficult because there was the house in Oromocto that was up for sale and his wife's living arrangement

in Nova Scotia with her parents, I believe, and Mr. Desmond talked about that not always being the best environment for him. That sometimes the relationship with his in-laws would be a bit conflictual. So he did talk about that when we first met.

Q. What about sort of the context of, you know, as a rehab plan? So what about job skills, employment, did that come up?

A. Yes, Mr. Desmond was, you know, a relatively young veteran and he talked about having aspirations of maybe some day working in the civilian world. He mentioned policing might have been of interest to him. However, at the time, I think he recognized that he wasn't necessarily ready to, you know, start job searching or learn about job searching because he did admit that having joined the military at a young age, he didn't have a whole lot of practical knowledge about resume writing and that sort of stuff. So it was sort of clear, and I think mutually agreed upon, that vocational rehabilitation would probably come at a later stage because there were other barriers that needed to be addressed at that moment.

Q. Just to kind of talk about the rehab plan for a second. Is that something that VAC has a specific timeframe on? Like you must complete your rehab plan by "x". Like you only

get two years or something like that or is it case by case?

A. Not at the time. It's possible it changed. When I worked there, I always tried to, as a best practice with the veterans, we were encouraged to not make, you know, the rehab objectives for 10 years from that day because rehabilitation is about engaging and, you know, advancing and progressing in treatment. So, as a general rule, I would work with the veteran and say, let's talk about, you know, two to three years from now, where would you like to see yourself. Like when we were setting up the, what I called earlier, the sort of umbrella objective, their main objective for rehab. And some veterans would struggle. They'd say, I don't know what I want to eat for supper tomorrow. But we would use that as an opportunity to just sort of learn about their interests and what was most important to them, and then we could agree on a mutual objective.

I usually looked at a two-year timeframe and then would say to them, you know, it's not about pass or fail. Like if we see that you're having difficulty meeting that, then we'll revisit. So then from that objective would come some more concrete goals. There was a rehab officer who would encourage us to present to the veterans the rehabilitation program sort of as a look at it

as the image of a staircase. So, at the top of the staircase, is this main objective where you would like to go and then we're going to then take it one step at a time to see what we need to address.

So my job collaboratively with the veteran is saying, okay, what barriers do we need to overcome to get to this main objective. So that's sort of how the rehab plan gets created and we have the information in the AC assessment to sort of inform the priorities and the needs. And, in Mr. Desmond's case, we also had sort of the added benefit of Dr. Murgatroyd and Dr. Njoku's recommendations.

Q. So that's an area counsellor assessment would form the case plan that you're also drafting.

A. Yeah, and you actually at the end had to finish your counsellor assessment so that you could open the case plan. So they really followed each other, I guess.

Q. Okay, thanks, that's helpful to understand. On, I think it's page six of, staying with the AC assessment again, and I don't see page numbers on it, but it's a document and the page starts with "Psychosocial Profile". I just want to talk a little bit about that with you. What was your understanding of Mr. Desmond's social supports and social history?

A. At the time that I met him, isolation seemed to be a theme. Again, I was meeting him in Oromocto where he lived alone. He didn't engage much with the community around him. That was information that he freely reported. And as far as close supports, like I said before, so we always try to find out like who are the people around you that you can lean on, that can help with different aspects of your rehabilitation. And his answer to that was pretty much my wife but, you know, our communication isn't really the best right now. So he suggested that he wouldn't rely on her because of that or as much because of that.

So he talked, obviously, about his daughter and I don't think it's documented there but I have, you know, I would ask him about his family at large, are there other members of his family, and he seemed to, you know, want to keep to himself a lot.

I remember asking if when he went to Nova Scotia if he visited with his immediate family and, you know, in a very sort of loving manner he said he didn't necessarily like to visit the family home because it was loud. So he didn't like engaging too much with crowds or whatnot.

(12:20)

So, yeah, the sort of snapshot that I got was someone who was somewhat isolated and was wanting to feel better. Like he talked about his emotional difficulties and very much wanted to engage with professional help.

Q. What about care support or peer interactions, was that something you talked about?

A. I believe so. I don't remember if ... Yeah, so OSISS, oh, I'm trying to remember the acronym, Operational Stress Injury Support Program, or Support Services, I think. So, basically, these are people who have, you know, quote/unquote, have walked in the veteran's shoes. So with OSISS, it's usually a former veteran who has training to provide good or some peer support. So I had talked to him about that, seeing as he felt like he wasn't engaging too much with the community around him, like he mentioned, I mention here that he had gone a few times to the Marijuana for Trauma office, which is known to be groups of veterans who would meet there but he wasn't sure that that was the right place for him. So OSISS, and my perspective, and based on what he was telling me, seemed to be potentially be a better fit. And OSISS could provide support, peer support, in a one-on-one capacity or in a group capacity. So I definitely encouraged him to do that and always

made the effort to sort of say, you know, call the OSISS peer support coordinator by his first name. Oh, do you know so-and-so and so, yeah, he definitely was given the information, encouraged to engage. Because I think it is a positive and safe place for a veteran who is feeling isolated to land. If I remember correctly, I think he might have engaged once or twice in an OSISS initiative but didn't make it sort of a regular ... didn't develop a habit of reaching out.

Q. Just going through this towards the end, page eight on the same document, the section on financial issues. So what can you tell us about your discussions about the financial aspects of Mr. Desmond's situation at that time?

A. Finances was sort of a reoccurring theme throughout the work with Mr. Desmond. It was clear he was preoccupied by his finances and he made that known from the beginning that his income wasn't sufficient to meet his obligations or bills or whatnot that he needed to pay. Yeah, so he was saying he could meet his basic needs at the time which is, you know, the basic. We want to make sure that veterans are not struggling to meet their basic needs. But, yeah, as you will see, like if we do a chronological ... if you continue to go chronologically, you will see that finances, he kept bringing finances up as a

concern of his.

Q. So after you do this. You said earlier this is sort of like a necessary step before you can open the case plan. So we can go to the back document but first I kind of want to figure out, there's a document called a Risk Indicator Tool.

A. Yeah.

Q. Which is Exhibit 277. Is that something that you completed alongside this area of assessment or when did you do that?

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

A. Yes, so the Regina Risk Indicator Tool R, which is for this profile of a veteran, is always completed at the stage of an initial case manager assessment, like where you see at "Reason Completed". And, essentially, it has to do with the risk or the odds of successful re-establishment. So it's mostly self- reported info but when you see source of information, I checked off "professional" because we also had, at that time, some of the information that he was providing was supported by professional evidence. So it adds a little bit of weight, if you like, like confirms things. Yeah, so I think if we go all the way to the bottom, that we scored high risk in terms of his odds of positive ... or successful re-establishment. And this

is, I mean it's important information but it is kind of a monitoring tool. So I believe there was one done prior by a Veterans service agent and, if I remember correctly, we would do another RRIT at time of disengagement. So we get a sense of what's changed over the course of rehabilitation. So I guess my understanding is like it says high risk. It doesn't mean right now he's at high risk of like his immediate safety is at high risk or anything like that. It's more about what, how right now at this moment based on the information he's reporting, how can we expect him to do, basically, or to succeed in rehabilitation. I, unfortunately, can't, because I don't, there's like a competing document and, if you see added risks and there's a number for there. So I checked off one, "added risk", and that usually makes the score jump a little bit. There were categories of risk that I don't remember all off the top of my head but, based on information he provided, I would have identified that particular risk. So, yeah, so the RRIT is informative, not sort of the driver of the case, if that makes sense.

Q. Based on sort of like a baseline then and you're going through to do ...

A. Yeah, you could call it ...

Q. Ongoing.

A. Yes. And, initially, you're probably aware of that, but initially the Regina Risk Indicator Tool was designed, again, for a population because you see we talk about IEDLs and ADLs, so their ability to care for themselves and to complete their instrumental activities of daily living. So the original tool was really meant to assess the risk of a person needing long term care, so not being able to live independently. And then there is a modified version created because of the sort of changes in the veteran population where we were dealing with younger, you know, retired Forces member.

Q. And that change over time where you're talking about the different populations, the long term, you kind of think of maybe the World War II veteran population. Were a lot of the cases that you were involved with have a mental health element to them?

A. Do you mean in my experience?

Q. As a case manager, yeah.

A. As a case manager in 2015, yes, many people on my caseload had psychosocial rehabilitation needs identified. And as far as sort of the more elderly veteran population, I didn't work as much with that group because of the time that has

passed. But I mean I've had several conversations with case managers who have been at that for several, several years and they describe sort of the change in the dynamic and the complexity of the needs, intensity of the work with that change of veteran profile, if I can put it that way.

(12:30)

Q. So we have the area counsellor assessment, the meeting, the risk tool. So the case plan, which is Exhibit 277 ... sorry, 117, that was like a document that maybe doesn't have one date. So it's something that you maybe continuously update?

A. Yes, absolutely, it's an evolving document. So it starts with, you know, that overview of the situation is sort of a snapshot. So coming out of the assessment process, here is a snapshot of this veteran's situation, and then we work, like we create the objectives and then specific outcomes and we were trained to use, you know, the SMART goal philosophy so that, you know, goals would be timely and measurable and all that. So some objectives sort of expire and it can be six months, in a year. So we revisit them with the veteran to say, okay, well, was it achieved, yes/no, why was it not achieved, and then we modify as needed based on their circumstances. And it all becomes part of sort of evidence of whether they're progressing

quickly or not so quickly in rehabilitation.

Q. So thinking back to that time, January 2016, on this document, and feel free to look at it, it was sort of overview of where you want to be, what is preventing you from getting there. You talked about long-term (risk barriers?) and desired outcomes. So just trying to think about where you and Mr. Desmond were at that time, what were some of the main goals?

THE COURT: Ms. Grant, I'm just going to stop you for a second. It seems to me that if we're going to look at a new area with regard to Exhibit 117.

MS. GRANT: Yes, briefly, though, and then to turn into Ste. Anne's.

THE COURT: All right, but if you want to deal with that, that's fine. We're just approaching 12:30 and, so if you want to just maybe finish this portion of it and then we'll take a break for lunch. Thank you.

MS. GRANT: Okay.

A. Well, essentially, what I recall from that period is we have a veteran who seems to me pretty forthcoming about his challenges. So he talks about ... we talked about a theme of feeling isolated and talks about wanting to improve his marital relationship, he wants to be a good father. He is admitted into

... or eligible for rehabilitation as a result of his PTSD condition and he is struggling to manage emotions a lot. To support or in addition to that, we have already a recommendation from psychologists and psychiatrists who have engaged with him that say there is some work to be done with this person and we would like to engage in trauma work but right now this situation makes it difficult for this work to happen, therefore, our recommendation would be, and that's something that they've discussed with the veteran, of course, and then I, in turn, discuss with the veteran. So everybody seemed to be on the same page about, okay, well, maybe what we need to prioritize is the recommendation for implementation of treatments so that you are able to go somewhere and really focus on finding a bit more emotional stability and also sort of being in one place where the services would be offered. Because I think the travel between New Brunswick and Nova Scotia made it difficult also to maintain appointments. So, yeah, I'd say in terms of priority, that was probably the top priority. So we started the case plan or the rehabilitation plan working towards this first pretty big step, I guess.

Q. And this particular case plan also contains progress notes.

A. Yes.

Q. Okay. And references to resources that are funded by VAC.

A. Yeah, it's actually the place where we can authorize resources through rehabilitation. So we call them resource screens and there's a bunch of codes and language that is probably not evident to someone outside of VAC. So, yeah, that's an example of a resource screen. And the progress notes, so once we're engaged and the case line is open, any interaction that I have with the veteran, I'll be documenting in their rehab plan instead of in another section in CSDN.

Q. Because you want them together in one place.

A. What's that?

Q. Do you want that together in one place?

A. Yes, because we are monitoring what's happening sort of in the (French phrase) of the rehabilitation program. And then if ever we need to provide information to someone else in VAC, there are places that I can go and document, you know, information in CSDN, that that would be our main tool. And, as you mentioned, like an evolving document.

MS. GRANT: Okay, I think that's a good place to stop for lunch.

THE COURT: All right, thank you. Counsel, we'll adjourn and come back at 1:30, please. Thank you.

COURT RECESSED (12:38 hrs.)

COURT RESUMED (13:31 hrs.)

THE COURT: Thank you. Ms. Grant?

MS. GRANT: Thank you, Your Honour.

Hello again.

A. Hi.

Q. Just a quick sound check. I can hear you. Can you hear me okay?

A. Yes, I can, thanks.

Q. So where we left off, we were talking about the rehabilitation plan which is, I guess, maybe is it fair to say it was a living document?

A. Yes.

Q. Okay.

A. Absolutely.

Q. So we're going back now to December 2015. There is a letter of recommendation, it's Exhibit 115, where Dr. Murgatroyd and Dr. Njoku of the Fredericton OSI Clinic recommended admission, Lionel Desmond's admission, to the Ste. Anne's Hospital Inpatient Stabilization Residential Unit. So are you

familiar with that letter of recommendation?

A. Yes.

Q. So is this something that was required by VAC in order to action this recommendation?

A. Yes. Yes and no. I mean recommendations can come in the form of a letter. But, yeah, as a case manager, like I said before, we authorize resources but we don't necessarily have the expertise to be able to say, you know, this veteran requires inpatient treatment and just of our own. So we rely on this type of informed professional information to guide the decision.

So, yes. Having some form of a recommendation from a professional is part of the evidence that we need to support.

Q. And would that be also used to inform whether you would authorize travel-related costs, for example?

A. Well, I guess when we authorize a resource for a veteran to partake in treatment and there is a certain distance to travel, it's understood that health-related travel is something that can be claimed by the veteran so that they don't incur unnecessary expenses. Well, not unnecessary, but like additional expenses to participate in treatment. We don't want that to create barriers to participation.

So the health-related travel, where we're talking about

going to an inpatient treatment in a province away, it's understood that it's something that a veteran will request and be able to claim through their treatment benefits or the other rehabilitation program if that's the only way to approve it.

Q. So part of the report on Exhibit 115 states that Mr. Desmond ... "Client is not actively suicidal or homicidal. He is not at risk for aggression or violence. There are no present legal issues."

So, I guess, thinking back to receiving this letter of recommendation from these treating professionals, were you, as the case manager or the authorizer, in favour of this and thought it made sense?

A. In favour of the recommendation?

Q. Mm-hmm.

A. Yes. Yes, absolutely. Particularly once I discussed it with the veteran and saw that he, himself, saw a benefit to this. So there was no reason for me to not support this. I mean it was recommended by professionals who knew him and ...

Q. And thinking back to our earlier discussion about one of the goals is to eliminate barriers, how did that factor into this, your thinking on this particular step?

A. Which particular step, sorry?

Q. Of admission into Ste. Anne's, sorry.

A. Okay. So throughout their rehabilitation program, we are trying to address barriers to re-establishment in general. So, at this stage, in a decision like this one, we have the evidence that we need. We have the veteran consenting, saying, Yes, I want to do this. So there's not very many barriers to accessing treatment.

And then you raised the question of the health-related travel. So this is something that came up in Mr. Desmond's case where having to pay his travel upfront, because health-related travel is usually something the veteran is reimbursed. But he was expressing an inability to pay. And because it is a distance and it involves a flight, the barriers that we focussed on addressing was, Okay, how can we ... can we organize this in a way that we prepay the travel. So that's something that I was able to action with him but that needed approval at a higher level from the area director.

So in terms of barriers to addressing this particular decision, I mean there is also the step of consulting with a mental health officer, but I wouldn't consider that a barrier. Just part of the process to make sure we have what we need. And, but yeah. So the travel piece was something that we

worked on that required quite a few steps to address that barrier.

Q. And what of the aspect of trauma ... getting into trauma work? Was this something that would maybe facilitate that down the road?

A. Oh absolutely. So when you have mental health experts like Dr. Murgatroyd and Dr. Njoku saying, you know, We've met the client on a number of occasions. We see the need to engage in "x" type of treatment. However, they call it "instability". So that would've been an example of a barrier they were facing, or the veteran was facing, ultimately, to engaging in the treatment that it was perceived he needed. So the stabilization unit, in particular, at Ste. Anne's was, in that sense, addressing a barrier, meaning he could arrive and stay in one place and be surrounded by professionals who can help with, you know, the emotional challenges he was facing. If there were challenges around medication, that sort of stuff, it could all be addressed in one place over a defined period. And then the hope was that then he could move into ... there's a stabilization phase and then just the regular inpatient treatment and, eventually, move back into the community to work with the providers.

(13:40)

Q. So on that point, in the document on the second page of Exhibit 115, there's a note. Part of it is where Dr. Murgatroyd and Njoku say that ... and I've just lost it, so just give me two seconds. Oh. It's about midway through the page: "Once stabilized, client will have outpatient follow-up with his psychologist, his psychiatrist here at the OSI Clinic. He does not have a family physician."

So at that point when you received this, it was your understanding that once the admission was complete, Mr. Desmond would go back to that team at the OSI Fredericton Clinic.

A. Yes. Well, that was definitely the ideal scenario and what we would plan for him with the information that we had at that time and with the living situation that he was in at that time.

Q. And I note there that he did not have a family physician in New Brunswick. Was that your understanding as well?

A. Yes. There was a, I guess I could say, a shortage. Like it wasn't easy for ... depending on where you lived in New Brunswick at the time, so it wasn't abnormal that a veteran would be without a family physician right after release from the

Forces, but with Dr. Njoku in the picture, that sort of helps in that sense.

Q. And he could prescribe medication?

A. Yeah. He was in a position to do that.

Q. At the time when you're first coming aboard is December/January. Did you have any conversations that you can recall with Dr. Njoku or Murgatroyd about having a clinical care manager at that time?

A. Not that I recall.

Q. Do you remember the first time it came up?

A. The first time I remember the option of a clinical care manager being brought up and seriously considered was at the pre-discharge telephone meeting that we had with Ste. Anne's staff and I had asked Dr. Murgatroyd to be part of that call as well. And it was definitely like a unanimous, like everybody agreed that, at that time, given the changes in this veteran's situation, that the CCM would be an appropriate resource.

Q. There was some ... I don't have the reference, but there's some reference in the record to Shanna and Lionel being separated and that they were hoping to spend the holidays together. When you were first assigned, based on your initial meetings and information that you were gleaning, what was your

understanding of their relationship?

A. My understanding was they were still a married couple, living apart a lot of the time, and having some difficulties that he spoke about. I did see on file as well, a reference to them being separated but that's not the picture that he presented to me.

Q. So in ... I guess, going back, maybe going back to the case plan a little bit and thinking about ... I'm just trying to ... We're getting into the sort of where you're doing a lot of discussions about the Ste. Anne's admission. I just want to kind of backtrack a little bit and go back to the case plan which is Exhibit 291.

Earlier on, we talked about the sort of case manager goals or case management goals sort of in the abstract: Engagement and relationship building, assessments, analysis, case planning, consultation, monitoring, evaluation, and disengagement.

A. Mm-hmm.

Q. Can you just talk us through, sort of globally, a picture of like what did that look like for Mr. Desmond in terms of the case plan and those aspects?

A. Sorry, I'm a bit distracted because I don't think it's the right document on screen.

Q. Oh.

A. That's the area counsellor assessment.

Q. Sorry. Yeah, that was my mistake. The case plan is 117.

A. And, sorry, can I have you repeat the question?

Q. For sure. Just we talked sort of generally about the case plan and case management but, specifically, with respect to Mr. Desmond, in the context of a rehab plan, those various aspects of case management - engagement, relationship building, assessments, analysis.

A. Okay.

Q. Yeah.

A. Sure. So I'd say engagement was not a significant challenge with Mr. Desmond in the beginning. I'd say he was quite receptive to me visiting. I mean if you think about, you know, having to call a few times to try to engage, and, yeah, there were those sorts of smaller challenges, but he was someone who would pick up the phone and call if he had a question. So engagement was, I'd say, positive from a case management perspective. And in terms of engaging with services and providers, it wasn't perfect, obviously, as per the information provided by Dr. Murgatroyd or Dr. Njoku that, you know,

sometimes making the scheduled meeting was a challenge but, all in all, the sense that I got was someone who wanted help and was willing to put in some work to do that.

Then, when the question of Ste. Anne's was visited, again, like he was pretty upfront about saying, I think this is something I need. So there wasn't pushback at first. But in the months that followed, as he was awaiting admission, everything had been sent and there was a waiting period, then he sort of started going back and forth as to, you know, he grew impatient with the wait time a little bit. And so then we were ... My role, as the case manager, was about working on keeping him motivated because wait times to get into inpatient treatment is kind of unavoidable. It really depends on the number of beds and how many referrals they have and whatnot. So, I guess, in that period, it was working on motivation and making sure, or encouraging him to stay connected to his local providers because they weren't ... they were recommending this, but they were dropping him. They remained available in the interim and, again, when he would be finished.

So can't really speak to disengagement. I don't feel that we were anywhere near disengagement at that point. We were really trying to get a treatment underway.

I'm trying to think if there's a point that I haven't touched on but ...

Q. No, that's good. Moving into now sort of February of 2016.

A. Mm-hmm.

Q. What is sort of going on with the admission into Ste. Anne's that you recall?

A. As soon as he is on the Ste. Anne's radar, let's say, like the letters have gone in, they know he will be participating, that he's consenting to participate, he has the ability to speak to an admission nurse. I think she was referred to in one of those documents. So Ms. Rodrigues. And so there's conversations happening between myself and the veteran, the veteran and Ms. Rodrigues.

So, basically, the way I understand it is they want the veteran to feel prepared. Inpatient treatment is not a small undertaking. Like it requires commitment and energy. So she had made it clear that she would be available if we had any questions. So I don't know specifically in February, but February/March, we had some discussions with her.

(13:50)

Like I said, the veteran wanted to go. And then part one

requirement of the inpatient treatment criteria ... well, criteria to be accepted, was that they didn't accept veterans who were actively using medicinal marijuana. So he had to wean off of that. And that, in itself, created some challenges.

And other stressors would just come into play. Finances again. And that made him, you know, question everything again. Whether he was really ready to go. He was quite concerned about the sale of his house and how he was going to be away, so I think what I did in those few months was really just take the time to hear him out. Sometimes, you know, allow him to make certain calls about ...

There was a point in time where he decided he was going to postpone his admission. I think that was a bit later. And I mean that wasn't necessarily a recommendation of the treatment team, but just sort of rolling with what he was bringing up, then when he continued to encounter challenges, taking time to sit with him, talk them through, and then we revisited his decision to postpone and just problem solved around some of the stressors that he had.

Q. So that the problem solving ...

A. There was ...

Q. Oh sorry. Go ahead.

A. No, it's okay. Go. No, no. I'm good.

Q. Okay. The problem solving. Would one of those aspects be getting the approval to pay for the travel upfront?

A. Part of it. When that was made clear, when he sort of made it clear that if he had to pay upfront then he wouldn't be able to participate, my reflex, which is generally how I treat demands from clients or requests from clients is to say, You know, I can't make any promises, but let me look into it and see what we can do.

So there was a ... you had to actually demonstrate the financial hardship or financial obligations that he had and why it was that he wouldn't be able to pay upfront. So, in a sense, yes, that was part of problem solving, but it was unavoidable if we wanted the travel to be paid upfront. So that's one of the things that I met with him and we did that. I believe that might've been in February because it had to go to other people in VAC to be approved, so there was a bit of a rush on that.

I'm just looking at now the case plan. So, yeah. So we learned in February that he's officially accepted and it's made clear to him what the waiting period would be, what's expected of him in preparation. The nurse had encouraged him to consider the impact of weaning off the marijuana, so where he was

assigned to Dr. Njoku, that he could speak to him about this. And, like I mentioned earlier, Nurse Rodrigues showed an openness to just maintaining contact. So if there were any challenges, roadblocks, specific to admission, then she was an additional resource. And he did rely on her a few times. I think he had called her on his own when he made the decision that he was going to postpone admission. That was one example.

Q. With respect to the wait times, what was conveyed to you as a potential time that he'd have to wait?

A. Before entering the treatment? I see here that I wrote, "Four to five weeks", and I think in another ... for some reason, four to six makes more sense to me, but it was something around that timeframe.

Q. Okay. And you said that during that time, he, Mr. Desmond, could still see his treatment team at the Fredericton OSI Clinic?

A. Yeah. And the appointments did continue.

Q. And were some of those appointments by phone, to your knowledge?

A. Possibly. Possibly. I don't know a hundred percent, but I know Dr. Murgatroyd had mentioned, over the course of our work with the veteran, that he had accommodated some telephone

appointments when the veteran was in Nova Scotia.

Q. You had indicated that, and we've heard evidence earlier in the Inquiry, that Mr. Desmond had to be not taking medical marijuana for admission as a requirement.

A. Mm-hmm.

Q. What about the issue of psychotropic medication? Was that something that you recall being talked about?

A. Yeah. There was some discussion about that because the medicinal marijuana was essentially what he was relying on in terms of medication. Nurse Rodrigues obviously framed it as, You know, chronic pain issues may surface, so you could talk to your psychiatrist about that, but also talk to the psychiatrist because coming off a psychoactive drug can obviously have, like have an impact on any individual. And I recall Mr. Desmond saying he had had a prior negative experience with psychotropic medication. He didn't go into great detail as to what the negative side effects were with me but, you know, when that came up, it was obviously encouraged to have an open discussion about this with Dr. Njoku because he was the subject matter expert.

So he initially didn't want to take any other medication. And shortly before going to treatment, I think he had changed his mind and agreed to take some, at least until he got to Ste.

Anne and that could be re-evaluated when he was in the care of professionals there.

Q. Do you remember having any discussions with ... we talked about the VO person, on the issue of back pain and adding that health condition to the rehab plan because, I guess, and correct me if I'm wrong, wasn't the rehab plan tied to a condition?

A. Yes. So, in his case, it was a group based on PTSD which was a service-related injury. And when we did the initial assessment, he spoke a lot about his chronic back pain and the barriers that was causing. So I had mentioned to him that he can ... You can add ... like it's possible to add a new condition to your rehabilitation plan so that we can include that in the process and get treatment for that. So part of that process would be another decision being rendered. So he would stay in the rehabilitation program, put in an application for an additional condition - it was a different form, I believe - and, from there, we would see about rendering a decision.

So I did ... yes, I do. I remember seeing that in my notes and I had a consult with his CO regarding that and ... because he had filled out the form. And CO looked at ... together, we looked at what we had and we didn't have sufficient medical

information to tie the injury to service. So, essentially, at that moment, it was, we will need more information from the veteran. And not that it was not important, but where we were in the process of focussing on getting him in inpatient treatment, we didn't spend a lot of time on this. Well, we didn't ... I don't recall spending too much time on this with him in those months where he was awaiting treatment because he was already naming a number of other stressors so that was that conversation.

(14:00)

This would have been conveyed to the veteran that we were going to need more information. So it would be at that point on him to go see the medical professional or if it was in his ... if there was evidence in his health records from the past, then that may be something he can put his hands on through a prior treating professional.

Q. When do you recall receiving a tentative admission date?

A. Uh-huh.

Q. Was that in ...

A. Oh, when? Sorry. I believe the first tentative admission date was for end of April - early May. Not sure

exactly when it arrived, but I know it's in the notes. Yes, so mid March. And at that time, he had had the conversation with Nurse Rodrigues that early May was going to be his wife's university graduation and he really wanted to be there. So she accommodated that request and said that they could be flexible and admit after May 1st. And it was after that that, I believe, that then he decided he wanted to postpone to end of summer. And he shared that with Nurse Rodrigues before he shared it with me, I believe.

Q. So is that around April ... around-ish ...

A. Yes.

Q. ... that he had thought about putting this off until the end of August?

A. Yeah. So there's a note here, early April, that he wishes to postpone his admission to August. "States he wants to engage in treatment at a time where he has a clear mind." That was ... were his words. So she, again, said, you know, it's the veterans who decide. We can't force the veteran into treatment. So she was accommodating and said, Okay, asked him to be in touch in July so that they could prepare for an admission late August.

Q. And with that sort of information, what did you do

with that in terms of steps that you took with Mr. Desmond?

A. Well, at first, you know, just ... there's a term in like motivational interviewing that's called "rolling with resistance", so I was sort of just rolling with what he had decided. Obviously, took the time to hear him out on, Oh, like if you want to tell me about this change ... you know, this sudden change in plan. And that's when he named the different stressors, house and finances being one of them.

So, obviously, my role as a case manager, is about again addressing barriers, so offered at that time, well, if there was anything I could do to help deal with some of these perceived barriers and so that he can maintain admission or, you know ... didn't necessarily have to be postponed until end of August. It could have been a different date. But initially did not want ... he declined my help. So that was fine. I rolled with that.

But then later on he calls back ... or we have a new conversation where he is in a bit of distress over his personal situation, so there's an opportunity to just sit down with him and hear him out on that and then see about, Okay, so what do you want to do? This is the situation now. And then the topic of inpatient treatment comes back and we're able, this time, to look at these concerns that he has.

And, I mean, it's like in any situation sometimes when ... as an individual, we see barriers and just having another person be able to say to us, Well, have you thought about ... for example, with the sale of the house, Have you thought about seeing if there was a possibility to extend that contract? Because he was afraid the contract would run out while he was away.

So when that was put forward to him, then he made the phone call himself and was able to ... he was granted this extension. So then he was recommitting to treatment, not waiting until the end of August, because he recognized that he wasn't doing the greatest and that it was the recommendation of his treating professionals all along.

Q. So that issue with the house was somewhat alleviated or ...

A. Uh-huh.

Q. Okay.

A. Yeah. Not in the first conversation. But, like I said, when he called another time and he ... there were times where he called and he was upset about "x" situation and then I would take time to actually listen to the concerns and then see about what could be done. So that was an example of that.

Q. Were there some other stressors that were kind of impacting this, maybe, decision to postpone or not?

A. Yes. Well, mostly the house. He talked about finances. Let me just revisit the notes. Yeah. He felt that some ... you know, there were some bills that he would have to take care of over the summer and that he had to be present in order to deal with that. So I think it was mainly the call to group (inaudible). I recall him, I think, meeting with his bank about some financial stuff. And the difficulties in his relationship were, when you read this, more of a motivating factor to reconsider treatment earlier.

Q. So you had said earlier that, when we were talking about the area counsellor assessment, that finances and financial stuff was kind of a theme. Is this an example of that, you're thinking of?

A. Yes. Yes, it was from the assessment and, again, multiple times over the course of the work with him. He had raised the stress of financial obligations as an issue.

Q. So what about the issue of medical marijuana? Did that pop up again?

A. Yes. He had ceased usage but was finding that a bit difficult. So in one of our conversations, he mentioned that he

had resumed using marijuana but at a lesser frequency or in a lesser quantity, because he knew that if he was going to go to treatment he would have to just cease usage again. So he talked about using the medication more responsibly. And he was able to be clean of marijuana in his system prior to his admission end of May.

Q. So April into May, there was some motivation on your part. But, at this point, it's your understanding that he had sort of changed his mind now and did want to go to treatment.

A. Yes. Almost as though he recognized that, you know, despite the things that were causing stress, such as finances and whatnot, there was still a need to be working on some of his own emotional challenges and that treatment was a place where he could go do that for stabilization.

Q. In May, did you meet with Mr. Desmond in person?

(14:10)

A. In May? Yes. I think ... yes. I think end of May was when he went to treatment. So I actually accompanied him to the airport on the day of his departure. It was not at his request. It was something that I offered to do. Not necessarily a typical case manager task but the context here was I talked about how I was traveling from Fredericton to Saint

John daily, so I travel through Oromocto every day. Parking at the airport would have cost a fortune.

So the idea of me going to the airport with him was more in terms of being a moral support, because I knew he would be going alone and that this was a big step. So I proposed it to him and he was okay with that. So, essentially, we sat at the airport and had a discussion like we would have had in another face-to-face meeting and when he was past security and ready for boarding, I waved goodbye and he was on his way to Montreal where staff at Ste. Anne's would be greeting him on the other end.

Q. Just backing up a little bit, where Mr. Desmond had decided that he didn't want to postpone anymore, he wanted to go sooner, you would have had to engage with Ste. Anne's to get another admission date. So can you just talk a little bit about that process and the paperwork involved?

A. Yes. I don't recall it being like a complicated process. The paperwork that we needed to send for him to be admitted in the first place was already in Ste. Anne's possession and it was sort of on hold because he said he wanted to go later. So I think it was a matter of a few phone conversations, so between myself the veteran admission nurse and

they were able to offer a new date which was, in the end, probably around a month later than what was originally anticipated.

Q. What about the ...

A. Ah ...

Q. Sorry. Go ahead.

A. No. Go ahead.

Q. I was going to ask about coordinating with the OSI clinic. Did anything happen around that before Mr. Desmond left for Ste. Anne?

A. Yeah. Well, he maintained contact with his supports at OSI in that period. And I believe there was a time where I had also recommended he connect with them over some challenges he was experiencing. And then where he was going to be admitted end of May, you know, it was a small thing that I was able to do was just contact the OSI clinic so that they're aware that he would have a schedule conflict and just sort of inform them that if they wished to see the veteran before his departure then, if it was possible, to move the date of his appointment so that it take place.

Q. As the admission date approached, I understand you have two calls with Mr. Desmond. Can you talk a little bit

about the contents of your conversation?

A. Yeah. I ... so would it be okay to see the notes?

Q. Yeah.

A. I remember one call where it was, you know, doing some problem solving and then ...

Q. This is actually ... so my question comes from notes you actually prepared. So that's Exhibit 299.

A. Okay.

EXHIBIT P-000299 - NOTES PREPARED BY MARIE-PAULE DOUCETTE POST JANUARY 3, 2017

Q. I guess just for the purposes of the record, if you could confirm that you did, in fact, make these notes?

A. Yeah. I produced those notes as a chronology of events after the tragedy happened.

Q. So there were representatives from VAC that asked you to prepare that?

A. Yeah. I believe the request came from the Deputy Minister's office but came to me through my area director.

Q. So, helpfully, these notes are in chronological order. So I'm in May, which is ...

A. May 2015?

Q. Yeah. Page three. And this is on to page four, so

two calls with the veteran.

A. Okay. I'm just going to take a minute to re-read.

Q. Sure.

A. Yes. There was these two calls which sound like happened over the same day. They would happen where he would have ups and downs and he was in contact at a time where he described not having a good day and was struggling to prioritize. So that's part of our role as case managers is sometimes even though there's sort of a plan in motion that we have to stop and, you know, meet the veteran where they're at but then remind them of the supports that they have around him.

So, in his case, he had Dr. Murgatroyd who he technically would have been on a biweekly meeting schedule with. I think there was some inconsistency with attending appointments but it was still a possibility. So encouraging him to reach out, offering to help because he was having a bad day. So, yes, that did happen pre-admission.

And then in the second call, I'm describing a situation where he was feeling calmer and we were able to ... because I think this was pretty close to his departure date, if I remember correctly. So we were able to say, Okay, this is how much time you have left before you go, so what is it that you would like

to focus on and that you could focus on that would help you over that short period of time?

Yes, it's clear from what I wrote that as he was leaving for treatment, the situation between him and his wife was, you know, they were going through some challenges. He was sort of speaking up about that.

Q. Okay.

A. I just want to qualify, as well, like, you know, accompanying the veteran to the airport, the decision ... like I wouldn't have pushed that on him. If he had said, No, I don't want you to come then I would not have done that. But the decision is also influenced by discussions with regional mental health officer, not that she suggested I should do that, but just reminding us, or myself in that case, as a case manager, of the type of commitment that inpatient treatment represents and the importance of letting the veteran know that they have support and people are thinking about them.

And also in our conversations with Nurse Rodriquez, I had learned that the staff at Ste-Anne-de-Bellevue had ... she had like a special agreement with the airport where she could meet the veterans right at the gate as opposed to waiting, you know, past the luggage or whatnot. So when I knew he was going to be

taking himself to the airport and had been sort of flip-flopping about whether he wanted to go now or later, I thought, Well, you know, that's something that I'm able to do that can help, so just ... that was also part of the reasoning.

(14:20)

Q. And did you have some concerns that ... you know, at sort of the last minute that he might refuse to go?

A. Well, I mean I wasn't overly preoccupied by that, but given the back-and-forth, like I mentioned, yeah. I mean I wouldn't have been extremely surprised if he, at the last minute, decided, This is too stressful. I don't want to do it. So, yeah, I saw my role as being that sort of a moral support at that time.

Q. And in that role, I guess if you're faced with a person who may make decisions that may not appear to be in their sort of own best interest, like what do you do? And you said earlier you can't force people. But what are your tools that you use to try to deal with some of that?

A. Well, I mean it obviously depends on the decision. If a decision would be, you know, threatening to their life, then we become more directed obviously. That goes without say. But in the case where a veteran might decide against a

recommendation or a medication or decide against a recommendation for treatment ... well, first of all, it's pretty clear that, you know, pressuring someone into treatment is not going to produce really good results.

So the idea of ... like I mean from our perspective, I think it involves a lot of listening and really trying to understand what's behind the decision. Because sometimes it might appear to be one thing but it turns out to be something else. So taking the time to ... it sounds simple, but just really actively listen to the concerns, letting them know that they're in the driver's seat. That was an expression that I used a lot with the veteran. Like, You're driving this car. I'm here to, you know, sort of copilot with you, if you need help.

And so if they're making a decision that's not necessarily from the perspective of the supports in their best interest, then at least I will engage them in, you know, to their reasoning. And if they want to talk about it ... and most times, you know, they're just open to talk about it. And then accept that that's the decision that they've made.

And sometimes an opportunity arises where you can revisit, especially when the decision proves to not be working very well

for them. So I guess patience is part of that and just knowing where the limit of your role, that it's, in the end, they're a voluntary client. They're coming to you for help. You can make the best recommendations with the best intentions, but ultimately they decide.

Q. So, in this case, we're at the point where Mr. Desmond has decided to go to Ste. Anne's and ... so end of May. So I just want to talk about that period of time which would be sort of June to August and what's going on with your involvement at that time during Mr. Desmond's stay in Quebec.

A. Sure.

Q. Can you talk a little bit about your communication with Mr. Desmond?

A. Yeah. So my ... I mean my ... I guess my plan or my goal at this point, he's ... I know that he's in treatment, surrounded by experts and professionals of all kinds, so it's more about touching base, seeing how he's doing, letting him know that, you know, we're proud of him for what he's doing.

Obviously, one of the things that really stands out from the notes in June is his wish to have his wife and daughter visit. There's a holiday weekend in Quebec the weekend of the 23rd, around Saint-Jean-Baptiste, so he had hoped that his wife

and daughter could visit and was wanting VAC to pay for their travel. So you'll see that he'd had contact with some intake case managers because there was a short period where I was off.

He also spoke to me about it a little bit. I had mentioned to him to not necessarily get his hopes up about the travel being paid because as much as we want to help and facilitate things, we still have the responsibility to, well, spend taxpayer dollars in a responsible way and ... that's not how I put it to him. That's how I'm putting it to you. But just saying that I didn't know unless his wife was being asked to participate in an aspect of treatment, that there was a way that we could pay for that. But it was something he decided he really wanted and so he proceeded to contacting the intake. I think he spoke to two different intake case managers while I was away. And when the request was denied, he was quite upset about that.

So there was a period of time, end of June/July, where I knew he was quite upset at me and had asked to speak to a manager about the decision to not pay. So that was ... you know, that was, I want to say a small hurdle, from my perspective, because the VSTM team manager who contacted me and said, Well, here's the thing. We have a veteran who is

requesting a new case manager.

And I knew, you know, the back story, so we talked about it. I said, Well, this is someone that I've done quite a bit of work with so far. He's in treatment right now. Do we need to rush reassigning him or do we sort of let him continue treatment, let the dust settle a little bit, and then give him a choice? I said, I really think it would be responsible of me to have a conversation with him about it. I will let him know that it's up to him to decide.

So there was a few weeks that had passed and, as you mentioned, that his wife and daughter did end up visiting at their own expense, regardless. So ... and when I talked to him in July, he seemed to be in a better space. And I got an update from him and then, you know, mentioned to him, I realize that you spoke to a manager and I am not at all upset about that. I just wanted to let you know that I've been made aware and wanted to see what you want to do about this.

And he was immediately apologetic and I don't even know if he had said any things bad about me. Like that didn't make it back to me. But I just said, It's fine. I'm willing to continue working with you. I don't think the working relationship is completely ruptured but that is up to you and

then he confirmed that he was okay to continue as-is.

So that would have been July. And there was ... he mentioned that one of the things that had been on his mind while he was upset is that he was debating whether he wanted to stay. Like he was playing around with the idea of just leaving treatment. So I, in one of those conversations said, you know, I'm really happy that you decided to stay and you're, you know, already a good portion of the way through. And then he communicated his decision to leave treatment a few weeks early, that he had already communicated that to staff at Ste. Anne's.

And when I checked in with staff to see if they had any sort of ... if it was against recommendations, there was ... you know, there was no one saying, No, he can't leave two weeks early. They're like ... they felt like that was a request that they could respect the decision and ... so that was sort of another conversation that was had.

(14:30)

Q. At what point, I don't have the reference here, I'm sorry. I think you had conveyed at one point that it might not be a good idea for Shanna Desmond to visit. Is there something that ... you know, what ... kind of what made you say that or think that?

A. I don't remember what my words would've been that would've conveyed that. I can definitely say that it was, you know, I was with him at the airport before he left. There was conflict going on then he was quite upset about. And there we were, you know, a few weeks later. I understand that, you know, you miss your family. And I think whatever it was I said was more in the spirit of, You're here to focus on you for a period of time. And I guess I didn't want the fact that her travel may be paid or not to like be a deal-breaker for him, that he would quit on treatment because of that, because he was there for himself first.

So I was actually pleased to find out that she decided to go and spend some time with him because I learned that there was a lot of ... there wasn't much happening on the weekend. So it was a holiday weekend, he had a lot of time. So I mean I was definitely not against her visiting. I just ... I didn't ... I saw the importance of the veteran not being overly-focussed on that while in treatment.

Q. And I'm going to reference a June 30th, 2016 ... I think it's at Exhibit 273, page 10, of the VSTM client note dated June 24th. There's an interaction that you had with Kama Hamilton. Do you remember that?

A. Yeah.

Q. Can you just tell us what that was about?

A. I think Kama Hamilton was a social worker at the treatment facility. And I don't know if she ... I think she sort of played, I think, a case management-like role. So she was, you know, connected closely with Mr. Desmond while he was in treatment and she talked about some ... you know, just a general overview of progress and some challenges that they were perceiving. And she mentioned that there was talk about maybe obtaining more specialized assessment. She didn't go into too many specifics but I, at that point, I said to her, Well, if it's something above what we've already authorized within the inpatient treatment program, please let me know and I'll see what we can do on our end to maybe authorize that while he's in treatment in Montreal. If you have access to specialists and the professionals there think that her assessment would be important, then the way I can help is to try to get that resource approved. So there was that conversation that I recall.

Q. Was there an example of when you say "specialized assessment", what would be an example of that?

A. Well, it came up in the pre-discharge meeting that

they mentioned that a neuropsychological assessment would be part of their final recommendations because of perceived cognitive limitations. So it was clarified then exactly what it was that they hoped to see happen, but that was a month-and-a-half later, so it came out as part of a number of other recommendations.

Q. So you thought, though, that maybe this would be something that would be more easily undertaken in Montreal?

A. Well, yeah. I mean I expressed to Kama Hamilton whatever, you know, specialized assessment you're after, chances are you're surrounded with more professionals than we are. And, well, I knew what the situation was in New Brunswick. And so, yeah, that was sort of the rationale for me encouraging that.

Q. So if they had presented ...

A. And then trying to support that.

Q. ... something ... Sorry. If they had presented a person to you, you think that would've been something you would've approved?

A. I would've gone through the steps to approve it. Absolutely. I mean sometimes professionals can recommend things that are difficult to approve in the rehab program because of the links that we need to make to their condition. There has

to be like a clear rationale as to what barriers we're trying to address this. So, yeah. But that's the thing with case managers. We get creative and we go the extra mile to try to figure out with consulting. Whether it's IDT or policy experts, to see, Is this something that we can approve? We're not there to say, Well, such-and-such professional doesn't know what they're talking about. Like this is what they're proposing. Is it something that we can make happen? So ...

Q. So, in July, did you have any additional telephone contact with Mr. Desmond?

A. I don't recall exactly, outside of there was that one conversation where we talked about how he was doing and if we were going to continue working together.

Q. Was there any reference to the state of the ... you know, before he left, he had had some stress around the house. So what was that situation?

A. Oh yes, yes. So I think it was in July that he advised that his house had sold, so he was feeling very relieved about that. And then what that meant, though, was having to relocate upon the end of treatment, which is not an ideal scenario, but was going to be happening in this case. He was saying he was likely going to Nova Scotia to be with his family,

but exactly where he would move, he hadn't figured that out in July, I don't think. So there was some discussion about that in August.

Q. So, at that point in July, you were starting to kind of get the sense that he wasn't going to be going back to his treatment professionals in Fredericton?

A. Yes, absolutely. I mean we knew his house was for sale when he went to treatment. The risk of this happening was always a possibility. His house had been for sale for some time, so it could've not sold. You know what I mean? So it was, What do we do? Do we delay this person going to treatment because their house is on the market? So based on the recommendations, we decided there was probably more to gain from him participating and the veteran was consenting.

So, yeah. Come August, then it was about, Okay. So ... And I think it's clear to everybody. Like I'm sure you've heard from psychologists or any sort of treating professionals that they're authorized to work within their province of residence, so that was sort of the challenge, that he couldn't continue with the same people that had recommended his inpatient treatment and that were prepared to follow up, already had good knowledge of him, his situation. Yeah.

Q. So in terms of getting into the sort of last month of inpatient treatment in August and we understand there was a pre-discharge call and that you were on that call. What can you tell us about that?

A. Yes. Sure. So it was sort of a call in preparation for his return home. I believe I was the one who asked Dr. Murgatroyd if he would participate seeing as he was, you know, one of the recommending professionals and knew the veteran sort of from a therapeutic standpoint. He knew things about the veteran that I obviously wouldn't have known, so I thought it was important for him to be able to hear as well what the professionals at Ste. Anne's would convey.

(14:40)

So, yeah. There was a specific conversation from which I was able to take a few notes. And that's when the ... You asked about the clinical care manager resource before. Well, it was at that meeting that we sort of unanimously said, Okay, well, if we had to renew all of the professional supports around him or he needs to find new professionals, then bringing in a clinical care manager could be very helpful. And so then I went through the process of having that approved. And consultation with the RMHO was part of that.

Q. We'll come back to the clinical care manager for sure. What about other recommendations? Did you have a list of those or were they ... Obviously, this is by phone, so not ... you don't actually have the discharge report at this point.

A. Yeah. No. We're given a general idea of what they're going to recommend. Like I mentioned they mentioned the neuropsychological evaluation, but there's ... you like obviously don't have the complete list in front of us, like the hard evidence or what you want to call it. But it sort of gave us a sense of, Okay, well, what next steps do we want to take? And, also, we need to factor in the veteran's plans and wishes in that as well.

So, yeah. I mean I think it was a good meeting. We, in that meeting, had looked at different scenarios as well of how we could, you know, offer support upon his arrival. So with Dr. Murgatroyd and the OSI Clinic, because we knew he was going to be relocating really soon, we looked at the option of offering him an appointment after he landed in Fredericton. So not on the same day, but Dr. Murgatroyd had availability the next day, so it was in that meeting that we talked about, Oh, well that could be beneficial because then, you know, you get to sit with him, see him, like I mean he saw him pre-treatment, made

recommendations. It would be good if you could see him post-treatment, see what your observations are, and then talk to him about the next steps in, you know, working with a different, whether psychologist or a psychiatrist or whatnot, like the resources available in Nova Scotia.

So we thought that was a good idea, but when I proposed it to the veteran, he preferred to just go home directly from the airport, so he declined that final appointment with Dr. Murgatroyd.

Q. And was there any discussion of ... you mentioned before, the OSISS peer support? Was that mentioned?

A. Yeah. So I wasn't sure exactly what the veteran's plans were at that point for transportation from the airport. Like I knew his house sold but I didn't know all the details about his belongings and all that. So I think we had talked about, you know, encouraging him. I told him not to worry about the flight details and whatnot because I would be handling that piece through the prepaid arrangements, but that if he could think about his transport from the airport. Like did he have a friend or someone who ... But then, sort of as a safety net or extra support, we thought about OSISS who he had ... he had connected with the coordinator I think once or twice earlier

that year. So all I did was check in and see if there would be an opportunity ... was there availability on such date to support a veteran who would be coming home from treatment if they needed it? So that was offered to the veteran as well, but he, at that point, had made his own arrangements, so he declined that as well.

Q. And on the issue of accommodations, was that still kind of an open issue at that point?

A. Accommodations. You mean like where he was going to live or ...

Q. Yes.

A. ... like temporary? Okay. Yeah, he's saying he's moving to Nova Scotia. Where, exactly, he was not entirely sure. So there was a discussion about, you know, what did he think is best for him. And I believe that was a conversation as well with the social worker. He had that conversation with the social worker as well at Ste. Anne's about, you know, just past challenges that he had mentioned about living with his spouse and daughter with his in-laws.

So we did explore, you know, where he was at with regards to maybe finding a place of his own, like renting an apartment, something like that, so that he would have still that sort of

space of his own that he can retreat to, because he would say he didn't like crowds and that sort of stuff. But that was ... that seemed to be too overwhelming for him to arrange, so he ultimately decided that he wanted to go live with his spouse.

Q. Was there any more discussion about the medical marijuana issue or connecting with that organization when he returned briefly to Fredericton?

A. The only thing I remember is, you know, he had ... like I said, he had some interactions with Marijuana for Trauma which is an organization based out of Oromocto, but that he wasn't ... he was kind of hot/cold as to whether that's what he needed or ... But there was a ... he did mention in passing that he might instead get involved with Trauma for Healing, I think it was called. Now I'm not a hundred-percent sure what that is but my understanding was that he was not looking to re-engage with Marijuana for Trauma.

Q. In terms of the conference call or the pre-discharge call, what was the discussion or what was conveyed to you about the ... I guess sort of like the status of, you know, how things went, or progress, or that sort of thing? What was ... Do you remember?

A. Yeah. I remember documenting that it was a sort of

minimal amount of progress was observed. I couldn't go into great lengths other than to ... but that's what stands out for me from that. And then there was the veteran's sort of ... I remember ... you know, that's not all in my notes, but I remember the veteran talking about how he really ... he had done some massage therapy while he was there, and yoga, and those were the things that he had found most helpful. So it sort of makes sense, with the final ... I think he was doing a bit of woodworking as well as a hobby. So when they say minimal progress clinically, then that sort of aligns with what he described.

Q. So sort of if there was a typical list of recommendations, and maybe it wasn't sort of presented in that way, but coming out of that call, what was your priority?

A. Coming out of the call, I think the priority was, Okay, we now have someone who is coming out of treatment and who needs new treatment providers around him. So the CCM resource, to me, was something that needed to be prioritized because they were going to be someone sort of on the ground, familiar with Nova Scotia systems, and could provide sort of that extra help. And, like I said before, we have used CCM in other cases where there was a move to a different province or

someone might've moved to a major city or, you know, something that requires a lot of coordinating.

(14:50)

So that was definitely a priority and I think, in August, I was already doing the research and trying to figure out who we could set him up with as a CCM. And, because of the rural area that he was moving to, it was hard to find. Well, we couldn't find someone qualified and registered very close to where he lived, but there was one person who I think you heard from in the Inquiry, Helen Boone, who was out of Cape Breton and willing to take on that role. So the process to have her assigned temporarily as a clinical care manager in Mr. Desmond's case started technically in August. I also got the veteran's take on this and he was in agreement so ...

Q. Is that something he would have to consent to or, you know, be in favour of before you could set that up?

A. Yes, absolutely. Like verbal consent was satisfactory in terms of me doing the research and trying to find a provider, and then when the time would come for them to connect, they would be able to sign any consent form that they needed to sign for her to take on the role, I guess, so ...

Q. So you're prioritizing the clinical care manager.

Were there any sort of other ... like were there a list of recommendations prioritized in any way from Ste. Anne's perspective?

A. No. I mean the neuropsychological assessment was something that was mentioned that was coming through a final recommendation, so we certainly didn't lose sight of that. And the way I approached it was, every time I spoke to someone, be it a VAC employee, a manager, a potential CCM, therapist in the Nova Scotia area of where he'd be living to ask them, Do you know a psychologist who does this kind of specialized assessment? It's something that we're going to be looking into. And every time I came up against, No, not really off the top of my head.

So there was some research that was going to need to happen and something that a CCM obviously could've been a great help with, but it wasn't ... I didn't have like an order of recommendation to say, This is what you must prioritize. I sort of went with the supporting team's judgment and, based on the work we'd done with Mr. Desmond so far, the idea of him being in a new place without formal supports seemed to be an important priority or an important issue to address.

Q. What about the aspect of therapy? So leaving Dr.

Murgatroyd, the psychologist in Fredericton, to rural Nova Scotia. So what were you thinking in terms of that issue?

A. Well, I mean like I said earlier, it's not the ideal scenario when someone goes to treatment and, you know, Ste. Anne's like had expressed that. Like they accept people in treatment when they know that there is a team available to work with them upon release. It's out of the ordinary to release someone from inpatient treatment to no resources. So, in this case, you know, he had resources, the house sold, there was a move. So it was part of the reasoning for trying to get that appointment set up with Dr. Murgatroyd. You know, he could sort of land, see a familiar face who had done some psychological work with him so far and is in a good place to make some recommendations or to, you know, counsel veteran on what may be a good fit. And so when that didn't happen then, you know, the CCM was sort of another resource that I thought, okay, well this will be someone who can help coordinate the things that need to be coordinated, including a psychologist or trauma therapist or ...

Q. The various issues you talked about earlier. Sort of a general, what does a clinical care manager do that would be helpful in this context?

A. Yeah. So a clinical care manager, I think I said earlier, like a simple way to look at it is sort of like an extension of case management. So we're at a phase or a place in this veteran's rehabilitation where we're trying to ... there's a lot that we would like to see happen. So it's going to require more time, logically, to address the different needs. So the CCM working alongside the veteran is sort of an ally. They don't come in as a medical expert or anything like that. They have a background that is suited for the position. So either social work or psychology, nursing, occupational therapy, I think, are the four and they bring sort of that clinical lens to the role, but their role is really to assist the veteran in a more regular fashion, I guess. I think I talked earlier about if the veteran was calling daily then that takes up a lot of case management time. And so when there's more need, if we can have this other professional come in temporarily, the case manager remains in charge of the decision-making, like approving resources and whatnot, but the CCM is a support, sort of a more hands-on support, in the community. And, specifically in the case of Mr. Desmond, the CCM was the one that I felt, because of the geographical change too, would be a great asset in terms of knowing a bit more what was around, understanding, you know, if

there were any differences with the provincial system, because there was also the decision to maintain him on my caseload until we had some stability of supports around him.

Q. So, eventually, the plan would be then to transition to a Nova Scotia-based case manager?

A. Yeah. It was always the plan from the beginning. I just did not think it would be very sound to say, A person is coming out of treatment, oh, he's moving; therefore, I'm going to hand over the case to a brand new case manager while there's all these other things in motion, right? So this was communicated to team manager in New Brunswick, team manager in Nova Scotia, and there was no objection. So like I think they saw the logic in that decision and, in fact, the Halifax office manager was quite helpful and said, Well, let me connect you to some of our local case managers who know the area well and then so it was good in terms of having that extra support, knowledge of resources.

Q. Just so we're continuing to talk about the clinical care manager, was there a particular reason why Ms. Boone was ... you thought she would be good in that role?

A. Well, I want to say yes because she obviously was someone who had quite a bit of experience in her field but the

reality was, we didn't really have many other options.

I remember talking to someone from the Truro area, which would've been a similar distance from where Mr. Desmond would be living, but they didn't have any availability. So when she accepted, obviously, I was quite happy about that because I do think that she was very qualified for the role but she was also, you know, the person that I was able to find.

(15:00)

Q. And you had support from the regional mental health officer on that?

A. Well, yeah, like I mean I consulted with the regional mental health officer to talk about the fit of a CCM at this point in time in the case given. So they are there to sort of look at what we have on file and determine if we're within our rights, I guess, to authorize that. And so I spoke to our RMHO early on to try to get the support, the additional support for authorizing the resource. And then I recall a conversation with an RMHO, which I don't think is documented. It was a brief conversation later on that fall when there were some issues around the training being completed. So just wanting to clarify, like can we get the services started, this is what's going on with the training, and at that time I was reminded, you

know, that the policy that they need to have that training to operate. I'm trying to think of other conversations with the RMHO, see we've got documents for. Yeah, I also discussed with the RMHO my decision to stay connected with the veteran for a temporary period and they didn't object to that either.

Q. Did you talk to Mr. Desmond about what a CCM does?

A. Yes. When we first ... I first introduced that idea as, you know, coming from not just me but the, you know, staff at Ste. Anne and Dr. Murgatroyd, and how we saw that that could be beneficial. So I explained that they were not a VAC employee, that they were someone who we contract for a temporary assignment. So they weren't involved in his case in the long term but that it was someone who could help us as he's transitioning to address some clinical priorities and also some of the priorities that he was identifying for himself.

MS. GRANT: I am cognizant of the time to take me to a break but I'm trying to get to the point where Mr. Desmond leaves Ste. Anne's as a natural stopping point.

THE COURT: Certainly.

MS. GRANT: Back during the time where Mr. Desmond was at Ste. Anne's, we understood from evidence we heard previously that there was, I guess, what I would call it maybe a difficult

phone call between Mr. Desmond and Shanna Desmond where they maybe argued and I'm just wondering if you were made aware of that? Did anyone talk to you from Ste. Anne's about maybe their relationship status?

A. There's nothing about a difficult phone call that I recall, like that stands out for me. I do recall, I think it was Kama Hamilton, the social worker, telling me that she had engaged in a conversation with the spouse, which I thought was beneficial but nothing specific to, not that I recall, a difficult call or details about a difficult call.

Q. Did anyone from Ste. Anne or did Mr. Desmond himself talk about some very sort of vivid and disturbing dreams that he would have?

A. Not to me, no.

Q. On the topic of you said Ms. Hamilton spoke with Mrs. Desmond, did you ever speak with Mrs. Desmond?

A. No, I did not. Like I mentioned earlier, when we did the initial assessment, you know, there was a time where we discussed who his supports were going to be or were, and he had sort of made it clear that, you know, his wife was the next-of-kin and that, you know, normally she would be my main support but that we're not communicating well, it's not working, and he

wanted to focus on getting professional supports. But that's not an issue that I would push. And there was, I can't tell you exactly at what time but during the work that I did with him, at times because he was bringing up, you know, marital conflict as a source of stress, where I had said to him, If you feel that it would be beneficial to invite your wife to have a conversation with us, like you're more than welcome to do that and we can ... But he didn't, that's not something that he followed up on.

Q. Other than I guess what we've talked about already, did you see any other implications for your role as a case manager with Mr. Desmond deciding to relocate to Nova Scotia after he left Ste. Anne's?

A. Any more implications for my role?

Q. Yeah, we talked about you would have to kind of, you know, start looking for new supports and put new supports in place and figure all that out. Is there anything we haven't talked about that would ...

A. Well, I guess that, typically, when a person transfers to another province, the typical thing that we do is we, the file is, or the veteran's case is reassigned. But because of where he was at in his rehabilitation process, just coming out of treatment, didn't necessarily have a stable accommodation

plan. Like there was a lot of moving parts maybe. It seemed like that was the reason that I made that exception and said, you know, if he's in agreement and I like to stay connected until at least we have some stable supports in place. So I just wanted to clarify that, that it's not necessarily common practice but that it seemed to fit. I mean the fact that he was in Nova Scotia meant that from that point on, we didn't have a face-to-face meeting. Mind you, if I think about my caseload as a whole, Mr. Desmond is someone who I've met with face to face more than the average veteran on my caseload because of where he was situated in Oromocto and there were a lot of veterans to visit in that area so I could do some follow-ups once in awhile and there was ... I mean for me, there's a geographical distance, yes, but because most of our work is done over the phone, you know, I still saw that as something that could be manageable for a period of time. But, obviously, I'm not as familiar with everything that is offered in northern Nova Scotia. That's not my province of residence and so that's when, you know, having a kind VSTM from the Halifax office say, Well, how about I connect you to a few people who you can ask questions to if you hit roadblocks or whatnot in terms of resources. So that was beneficial.

Q. And you did do that.

A. Yes.

Q. We'll talk a little bit about that a bit later. So would it be as a best practice, though, to return to the treatment team that referred you to an inpatient facility?

(15:10)

A. Yeah. I mean I believe so, in my opinion, and that is something that was also, you know, conveyed to me as he was going into treatment at Ste. Anne's that, you know, ideally, you're released back to, you know, a familiar team and people who have, already have knowledge of you and give you to whoever made the recommendation that you came here so that they can continue building on the work that they started. That being said, I mean there was no one sort of necessarily questioning his reasoning for wanting to go back to his home province. I mean it was understandable that his home sold and that's where he wanted to go.

MS. GRANT: Okay, I think that's a spot where we can take our afternoon break, if it's okay with the Court.

THE COURT: Yes, thank you. Let's take a break and try and make it 15 minutes and then when we come back, I can tell you my intention is to continue to 4:30, take a break at 4:30

and then we are going to return at 6 o'clock and we will continue to no later than 9 o'clock. All right, thank you.

COURT RECESSED (15:15 hrs.)

COURT RESUMED (15:26 hrs.)

THE COURT: Ms. Grant?

MS. GRANT: Thank you, Your Honour.

Okay. Quick sound check again. You can hear you?

A. Yes, I can hear you. Are you good on your end?

Q. You changed your earphones but, yes, we can hear you.

A. Yes, I was starting to feel the pressure on my ears.

Q. Okay. So we're just heading into the sort of time period, trying to do this chronologically, so the period of time after Mr. Desmond is discharged from Ste. Anne's and your involvement up until January 2017. So if you can kind of turn your mind to that. And I know they're sort of ... in your mind, it's not broken down specifically into, you know, these months or whatever, but when Mr. Desmond is leaving Ste. Anne's, was there anything that you had to do with respect to his medication.

A. Not as he was leaving. Medication is not generally a rehabilitation domain, I guess, like something that we really get involved in too much. However, I think it was a week or so

after he returned to his home province that he contacted VAC because he had gone to the pharmacy and was trying to obtain one of his medications that was prescribed to him out of Ste. Anne's and it was one of those not on the list, I guess. It needed special authorization in order for VAC or Medavie to be able to cover.

So he contacted VAC and I got involved, seeing as I knew that the prescribing physician would've been out of Ste. Anne's and I had Ms. Hamilton as a contact. So I did, at that point, facilitate that process to have the information needed from the physician sent to special auth. unit of Medavie.

Q. So, to your knowledge, was Mr. Desmond ever without prescription coverage?

A. No. His treatment benefits follow him, which ... like the ... you've heard of a Blue Cross card that they get. This is something that he would've had, I think pre-rehabilitation, and that carries on post-rehabilitation. So the treatment, like the coverage was there.

(15:30)

In this specific case of the one medication that he was trying to get covered, he had the option to pay for a dose upfront and then submit to be reimbursed. But, again, to try to

alleviate, you know, any additional stress or barriers, I believe he decided that he just wanted to go through the process of sending things in to the special authorization unit, so we proceeded that way. But that doesn't mean that if he was taking other medication that were not special authorized, then he had access to those in the same way that he had before.

Q. And before our break, you were talking about how you had thought that maintaining Mr. Desmond on your caseload was the sort of logical view and that that was shared by the veteran service team manager.

Where you said earlier that you really weren't as familiar with some of the resources available in Nova Scotia, can you talk about some of the conversations that you had with the Halifax team and what those were about.

EXHIBIT P-000297 - PSYCHOLOGISTS IN YOUR AREA - EMAIL RE: PSYCHOLOGICAL COMMUNITY RESOURCES

And just if you need to refer it, there was some email correspondence about psychologists in your area, which is Exhibit 297, if you wanted to refer to that.

A. Sure.

Q. You don't have to, but just to let you know. So if you could tell us sort of what your communications were like

with the Halifax VAC people.

A. Sure. Well, the initial conversation I recall was with a VSTM, I don't know if I have to name people, but, anyway, if I do, I can, who ... out of the Halifax office. And he was ... I, you know, shared the plan to maintain him on my caseload and, as I said, like there was no objections. But he was the person who, you know, sort of initiated this or facilitated having me in touch with their right people because he knew his office and staff well and knew who would know the area where Mr. Desmond was moving to best.

So I believe he had given me the names of two different people that I could contact and he remained very open in me contacting him again if ever there was a roadblock or not.

So the emails. This is an example of a follow-up that I did with Mrs. Cross who is a case manager. Or was. I don't know if she still is. And because we, like we have the ability to go search, just like the general public, for names of psychologists, which we had done already, but then when there were a few barriers and veteran wasn't following up on these, then I thought, okay, well, I could ask also someone from the office if they have people they would recommend. And that's where the Catherine Chambers' name came up.

Q. And what about Helen Boone? Was she also mentioned? Maybe not in that exchange but ...

A. No. Helen Boone was someone that I had searched through the Medavie Blue Cross system to see who was registered as a clinical care manager and that's how I, myself, sort of stumbled upon her name, but I believe there may have been an exchange with a VSTM to say, I found this person who would be willing to do this, unless you know of someone who is in greater proximity to the veteran's residence because there's, you know, the cost of travel and all that we have to factor in. But, ultimately, Ms. Boone was the chosen one.

EXHIBITS P-000294, P-000295, AND P-000296 - NOVA SCOTIA CCM REGISTRATION (EMAILS RE: FINDING A CCM IN NOVA SCOTIA)

Q. I think that series of correspondences are marked as Exhibits 294, 295, and 296. They're emails, so there's not overlap in terms of the contents of them. They're marked separately. So just to give you a second to look at that. That was sort of part of that chain of your discussions about the clinical care manager.

A. I'm sorry. It's kind of blurry. I'm not able to read what's on there.

Q. Okay. There's an email from Ms. Nash-Butt, I think

...

A. Mm-hmm.

Q. ... who mentioned a potential clinical care manager, Sandra Preeper, I think?

A. Okay.

Q. And you said: "Thank you both. Please feel free to send resource suggestions my way at any time."

A. Okay. So at that point ... I'm just looking at the dates.

Q. I think September ...

A. I don't ... yeah, I don't remember if I contacted this Sandra Preeper, but looking at the date, I know that I had already initiated contact with Ms. Boone at that point. But I had called a few people ahead of Ms. Boone not based on any sort of favouritism, just based on the list that I had obtained through ...

Q. I think, if we go to the next page, you do mention Ms. Boone in the correspondence. There's somebody named "Doyle".

A. Yes, who is a veteran service team manager. I'm just taking a minute to read. So this has to do with the process of the CCM being trained in the BHSOL system at VAC. There were forms that needed to be filled out initially where you have to

identify the main office and we were limited in the way ... Anyway, it's just like a system thing. That's why I'm asking the questions about, Would it be okay if we identified the primary office as Halifax, because I had to assign her to the Saint John office because I was the case manager connected but just wanted, I guess, his permission to say, you know, If chances are, you guys are going to perhaps use her again as a resource, then people in New Brunswick won't. So I just wanted to make that clear.

So, yeah. And as per our telephone conversation. So some of this would've been discussed over the phone previously. And kind of assuming that he had suggested following up in an email on a certain detail, yeah.

Q. With respect to your communications with the VAC service team in Halifax.

A. Mm-hmm.

Q. Did you mention anything about the neuropsychological assessment?

A. I'm pretty confident ... Like I didn't document this, obviously, every time, but I'm pretty confident that when I had contact, whether it was with Ms. Cross, with Mr. Safire, I mentioned that this was a treatment recommendation and we were

going to have to be looking into this, and if they had any knowledge of a provider who specialized in this, because they're not on every street corner, as you can probably imagine.

So, yes, it was, you know, brought forward to a number of people, even the providers that ended up working with Mr. Desmond. So there was an informal search sort of happening behind the scenes, but we weren't there yet.

(15:40)

Q. So thinking about sort of the month, like in September. We're going to kind of get into October and I want to break down some different components of what was going on, but is there anything else in September that you were doing that isn't reflected in your notes or the client notes?

A. September. I know that the CCM was a big focus because there were a bunch of steps to get through and I maintained contact just so she would know what the process would be, to the best of my knowledge. Like the BHSOL training and stuff is not something that I have any sort of power over but I had told her that she could contact me if anything came up.

As far as Mr. Desmond, I know I documented those conversations about his medication. He had been calling about that. And I believe it was early October when the conversation

about OSI services in Nova Scotia took place.

Q. Yeah. So moving into October and discussions with OSI, let's talk about what was going on with that and what steps you were taking with respect to that issue with the Nova Scotia OSI Clinic.

A. So the Nova Scotia OSI Clinic made contact with me. They had Mr. Desmond's information. So my understanding had always been that it was New Brunswick OSI that had transferred over his name ... something. And I had a conversation with a nurse by the name of Natasha and I was on the road at that time. I remember being on the road and taking that call on bluetooth. And she clarified that I needed to submit a new referral which was news to me. Like I didn't realize that there had to be a brand new referral because it was part of the OSI Clinic network. So, okay, fair. So I told her that I was going to be in touch with the veteran ASAP and try to get that underway. And then I contacted the veteran, Mr. Desmond, and sort of ... and not assuming ... well, in a way, assuming that he would have wanted to continue with OSI services. So I told him, Listen, we have the OSI Clinic in Nova Scotia that would be able to take you on. Before I go ahead and do the referral I just, you know, need your consent. And that's when he told me that he did not

want to work with the Nova Scotia OSI and he mentioned that the distance to travel was a deterrent for him, that he would prefer to work with providers directly in his community or near his community. So we had a discussion about that.

I was a bit concerned about, Okay, well, what if it's not simple to find. But he seemed pretty confident that he would be able to. He had mentioned, you know, I can go to the St. Martha's Hospital. And I knew his wife worked there, according to what he had told me, so perhaps he had a familiarity with how that worked. And so I had suggested to him ... I reminded him that OSI was able to do telemedicine which, you know, back then - we're a few years pre-COVID - was actually kind of a rare thing. So what they would normally do is have the veteran set up in a local facility, whether it's the local hospital or clinic, and they could meet with their providers via what we're doing right now. Sorry. I'm losing my vocabulary. And, anyway, they called it "telemedicine".

So I talked to him about that and he was still not interested. And so the last piece I explored with him was, Well, what about psychiatry services because he, you know, had some things prescribed to him at Ste. Anne's and was probably going to need the oversight of a psychiatrist for medication

management. That stuff. I suggested that maybe it would be easier if he connected with a psychiatrist at OSI, and then if he wanted to work with a different provider for actual therapy, then that was a possibility too.

So we had that conversation. He decided that he wanted to work with professionals in his community. This is something that I clearly remember discussing with him. In reviewing my notes post-tragedy, I realized that it wasn't documented, (a) because I was on the road and (b) because he decided not to go ahead with it. I don't know if, at the time, I thought, well, move on to the next thing, but it was documented after the fact in a different report. So I just wanted to make that clear and ... yeah.

So, from that moment, then it sort of ... well, it generally falls on the veteran to say, I want to work with someone in my community. Okay. Who would you like to work with?

So in the month of October he ... that was the focus. I always kept him updated on what was going on regarding the CCM because I had thought that, as well, that it might go a bit faster than what had actually transpired, but I kept him posted on what the delays were and he was aware.

And so in terms of finding a therapy provider, which was definitely important, I had a conversation with him one day when he was having one of those days where he wasn't doing so well and expressed challenges. So I remember because I was about to leave for a week on vacation, so we took the time to sit and sort of say, Okay, well, I'm going to be gone for a week. What is it that you can do over the next week to sort of help how you're feeling and help move things along?

So we had made a little plan and I had taken the time to research some psychology therapy options for him. So I left him with the names of, and contact information of, three people in the Antigonish area. He was open to that and he was going to follow up and book an appointment, and when I returned from vacation, I would be checking in to see how he made out. There were other aspects to this plan. I think I recall him saying he wanted to go spend some time with the grandparents because that was somewhere he felt good and he wanted to look into a gym option to work out.

So that was in October. And when I returned, when we spoke shortly thereafter my return, he hadn't followed through on the calling one of the providers. I believe he said he lost the piece of paper that he'd written it on. He had looked into the

gym option, so that was fine.

So then I sort of asked, Okay, so what more can I do to sort of support this process? And that's when we determined that I can maybe make a call for him, if he felt comfortable, to see who had availability. And he agreed to that. So I was kind of, in a sense, taking on the role of the CCM as we waited for her to be approved to move things along. And, again, like I want to stress that the CCM is not there to do everything for the client, but if the client is running into barriers, they can be a person who sort of facilitates things.

(15:50)

So, yeah. And we found Ms. Chambers and there was, again, some delays with him following up when she ... I had spoken to Ms. Chambers, and I don't remember the exact dates, it's probably in my notes, but just asking her about her availability. So I wasn't offering a bunch of information about the veteran, but I was, you know, I was told that you have experience working with veterans. Do you happen to have availability at the moment? And it was, Yes. And so we sort of made a simple plan to have the veteran contact her and that we'd have the veteran say, I am calling you. My case manager, Marie Doucette, said that you would have ...

So that was sort of the plan. But then there was a span of a few weeks where, unbeknownst to me, nothing happened, and Ms. Chambers called back to say, FYI, I just want to let you know I never got a call from that veteran. So that is quite exceptional from a provider, in my opinion. So it was just reminding Mr. Desmond and encouraging him to make the call, which he thereafter did.

Q. You reminded him after you received that call from Ms. Chambers.

A. Yes.

Q. You said it was "exceptional". Do you mean to sort of follow up that, you know, to not get a call from a potential client or ...

A. No. Well, I find that exceptional in the sense that private providers tend to be very busy and they have clients coming in from whichever direction, so for her to call me back and say, Hey, you had mentioned that you were hoping to refer someone. FYI, that person never called. So, otherwise, I may not have known until I spoke to Mr. Desmond again. So that was helpful.

Q. Just to kind of go back to the issue of the OSI Clinic, you had talked about notes that you made after. And

that's Exhibit 299. If you could just go to page 6 just to clarify what you said earlier. So just wait for a second to pull it up and we can go to page 6.

So, for October there, I can see ink that's in black and ink that's in blue.

A. Mm-hmm.

Q. So when you made these notes, and we'll talk a little bit about that later, but what's the purpose of the different colour ink there?

A. I wanted to be very transparent about the fact that what was in blue was not taken verbatim or directly from my case plan although it had happened. I noticed, after the tragedy, like I said, I had this request, in the days that followed, to produce sort of a chronology of events. So as I was reading, and I read "October", I thought, oh, that would've been beneficial information to have, but I did not feel comfortable going in the case plan and, at that point, just throwing that in there as a late entry. So I decided to put it in this report, the blue ink meaning ... I probably wrote somewhere what the blue ink meant. And I had also, at that time thought, well, I can try to contact the OSI Clinic because I knew the contact had happened and they knew the contact had happened to see if

someone there would corroborate. And then I would feel better about putting that in the case plan as a late entry. So I contacted the OSI Clinic in Nova Scotia to try to speak to Nurse Natasha and, unfortunately, she didn't work there anymore. And the person I spoke to on the phone, like I didn't give too many details. I was just saying, There was a sensitive issue and I'm just trying to have her corroborate a discussion that we have had. And they had said, Oh, I'm sure that she would be willing to do that for you, so we'll see if we can track her down. But I never got a call back. She didn't work there, so I understand that that was sort of complicated. So, anyway, my decision was then to say, Well, it happened, so I'm going to put it in this report instead.

Q. It's on page 8 that you put your explanatory note there, if you want to flip to that. Yeah, in the highlighted part.

A. Yeah, so ...

Q. So you refer to "Nurse Natasha". And did you ever have her last name or receive her last name, to your knowledge, or that you recall?

A. Well, I think I've since heard of her last name but like it didn't register with me. Like when I was calling back,

I knew her first name was Natasha, but I hadn't documented it so, no, it wasn't clear.

Q. So the Inquiry did hear evidence from Natasha Tofflemire who worked there at the time and did speak with you. Do you recall, in your conversations with Nurse Natasha, whether there was any suggestion that you could only access OSI services at that time if Mr. Desmond had a family physician?

A. That is not something that I recall from our conversation. That's not to say that she didn't say that. To me ... if it did happen ... like I don't want to deny that that happened but I don't remember that. So I guess I can only ... It's one of two things. Either, to me, that was like, Okay, we'll roll with it. We'll figure it out. But the reason I find that sort of surprising is that, in New Brunswick, he didn't have a family physician, yet he was accepted into OSI services. So I don't know if it was a Nova Scotia-specific thing, but I don't have a recollection of that piece of the conversation with Nurse Natasha, no.

Q. And as your first step, you found out that you needed a separate referral. That was the process at the time. So from your perspective step one was to actually see if Mr. Desmond was interested in obtaining OSI services.

A. Yes, because they don't refer without consent. And I'm pretty certain that I called OSI back to let them know that he had decided against their services. It is possible that that was left as a voice mail. I don't know exactly. Don't remember exactly.

Q. Did you have any conversations with the Fredericton OSI Clinic after Mr. Desmond was released from Ste. Anne's?

A. I don't know right off the top of my head. I know that they wrote when they closed the file and ...

EXHIBIT P-000298 - LETTER FROM DR. MURGATROYD TO MARIE-PAULE DOUCETTE CLOSING NEW BRUNSWICK OSI FILE (AS RECEIVED BY VAC)

Q. Just looking at that now. It's Exhibit P-000298, just if you needed to look at it to confirm. I know this is in December, but this is something that you received for the file, that they closed their file in New Brunswick.

A. Mm-hmm. So it sounds like, according to this letter, that Dr. Murgatroyd and I, would've had a conversation in the fall. I trust that when he says, "As a follow-up to our last conversation ...", I don't have a clear recollection of that, but if he wrote that in December, then it's possible that I would've shared with him that he was connecting to professionals in his local community.

Q. So I think, still going back to October. And was there anything else on this issue of the OSI Clinic that you can recall? Conversations either with Mr. Desmond or Nurse Natasha?

A. Not specifically. I just remember being in the car when I spoke to Natasha and Mr. Desmond on that specific matter.

Q. So you did ... yeah. You said you may have left a voice message that said that Mr. Desmond wasn't interested in those services at that time?

A. Yeah. I'm pretty sure that I transferred that information to them. I can't say for sure if I spoke to someone live or left a voicemail.

Q. And you had mentioned that there was a time that you were away during October, so did Mr. Desmond have any interactions with VAC during your absence?

A. I believe he did based on some documents that I reviewed, like a screening of some sort.

(16:00)

Q. The screening document that we talked about or ...

A. Well, I think it was a client-initiated screening dated October 22nd or something.

Q. Yes. Is there anything that you sort of recall about that?

A. I reviewed it. It's not something that really stood out to me before I reviewed it. Reading it, it sounds like he was talking to the intake case manager while I was away and he was having a difficult day and they documented ... I think they described him as being agitated when he called. Keep in mind, I had contact with him just prior to leaving for vacation and the plan was to contact him soon after I returned. So when I spoke to him the next time he, like, wasn't presenting as agitated. So I don't know that that piece is not something that ... I'm not saying I didn't see it at the time but it's not very clear to me if we had discussed it further.

Q. In October, was that the time where you received the discharge report from Ste. Anne, a paper copy?

A. Yes, early October. Yeah, I remember one phone call I did to follow up on that and a report arrives early October. So that was useful to be able to have a chat with Mr. Desmond about what wasn't there, his priorities, and then what were we going to collaboratively tackle.

Q. So that document that you received, I believe, is marked as Exhibit 116 and it's October 7th. So is that round about when you think that you received it?

A. Yeah.

EXHIBIT P-000116 - MEDICAL INFORMATION FACSIMILE TRANSMISSION

Q. We've just heard evidence from witnesses from Ste. Anne that said it was their general practice to provide clients with a copy of the discharge report but it doesn't seem like, we don't know, but it kind of doesn't seem like Mr. Desmond got a copy of that. So do you have any understanding of that practice or whether he would have received a copy?

A. Unfortunately, he was the only veteran that I had who had received services at Ste. Anne. So I don't know for sure if it was like standard practice. But I would doubt that he had a copy if mine arrived in October. I know that I did take the time to discuss the contents with him so I guess I am ... it's kind of safe to assume that he didn't have his own copy. And I just want to mention that that's not out of the ordinary for a provider. Maybe some provide reports directly to the client but many will just send them directly for the purposes of case management.

Q. Did you have any conversations with Mr. Desmond in and around October about, you know, how he was doing with his personal situation and living situation?

A. Yes, again, right before I was leaving for, taking off for a week, we had a conversation and he was expressing

struggling at that time. And then he would have expressed maybe more of the same to a colleague. Yeah, I think was talking about, again, the family situation and the stressors that had been there sort of all along.

Q. Is there anything in particular you can recall about those stressors?

A. I'm sure there's some of it in my note. I recall making a plan with him to sort of ...

Q. So let's talk about the clinical care manager and the BHSOL, and we hear from Mr. Marshall a bit about what that is, but it stands for benefits and health services on line, I think.

A. Uh-huh. Yeah.

Q. And my understanding of it is that it sort of allows these external providers to upload their required information in a way that, you know, VAC can receive it. So the systems talk to one another in that way. Is that kind of a fair maybe (inaudible - audio) ...

A. Yeah.

Q. ... explanation?

A. Yeah, it was used specifically with CCMs because they're usually like sort of an individual who contract their services out. So they're not necessarily like a business with

all the setup of a clinic or something. The system allowed for them, when they first meet the veteran, to ... they don't do like an in-depth assessment, that's not their role, but they together agree on the things that they're going to look to focus on together and then that's transferred over to us through the BHSOL. So I would go into the system and review their report and, if it wasn't, I won't say satisfactory, it's not like a grading thing, but I mean if it needed further discussion, then I could contact the CCM or I could just finalize it and then it would transfer over to his file in CSDN. So I think if you spoke to Mr. Marshall, he probably told you that the providers are registered with Medavie Blue Cross but then a lot of times we have providers who are registered there who haven't yet engaged with a veteran client and that's where the BHSOL training in this particular case was something that had to be completed. If she had been working with other veterans prior to, she would already have her access so ...

Q. Okay. So the documents that we have suggest that there was ... she was scheduled to take this sort of training, BHSOL training October 27th.

A. Yes.

Q. What happened with that?

A. Well, that was right around the time that I was away and when I came back and we spoke, she mentioned that she had started her training and, unfortunately, there was a power outage midway through the training so she wasn't able to complete. So that was frustrating but, you know, no one's fault. So then I think what I tried to do was advocate internally to, I don't remember who exactly but the people at head office who deal with this training and wrote to say is there a way that we can rush this. I mean we've been working on connecting this provider to a veteran for some time and so I tried advocating in that way. And I don't remember, I think she was able to complete it soon after but then there was this issue of a missing form that both Ms. Boone and I were sort of agreed that we had already completed that form and it had already been sent. So I think that was like the last hurdle where I said, Okay, well, we're going to go ahead.

Q. Because just to clarify go ahead, so normally the policy was you'd have to complete that training before you could start engaging ... the provider could start engaging with the veteran.

A. That's what we were taught, yes, and I mentioned earlier of a call to an RMHO. Like I remember feeling, having

been frustrated with the process and contacting the RMHO just to clarify like, okay, am I understanding this correctly or can we find a way for her to work with the veteran and it was just reiterated to me that that was the policy. So we waited until the training was done. But when another sort of barrier came up, then we're like, okay, well, the training is done. So we're going to go with that. And I think her access was completed at a later date but ...

Q. So she did start working with Mr. Desmond prior to that piece of it being sort of completed for policy.

A. Yeah. Well, the policy was ... The way I understood it, or I don't know if it was policy or directive exactly, was they have to complete their training. So when it was clear that she completed her training and then they were just asking for additional paperwork, that we both were adamant we had already submitted, then I just said, Okay, well, I'll give you the go-ahead and, if there's a consequence, I'll deal with it.

(16:10)

Q. So after you got back from the week that you took off, we're getting into November. So is there anything else about communications in October or work with, you had mentioned with Catherine Chambers, she had contacted you. Is there anything

else that we might have missed in that timeframe when you received the report.

A. I'm not entirely sure.

Q. When you received the report ...

A. Yes, yeah.

Q. When you received that discharge summary from Ste. Anne's, was there any indication that there was any more to come or was that your understanding that it was sort of complete?

A. Well, I was ... When I see a discharge summary, I know that there is probably more to this because it's only a summary of what was completed and I don't believe that it covered, you know, all the professionals who had worked with him, but it was still a good summary of recommendations. So I didn't expect any more than that but it is possible that more arrived later on.

Q. So moving into November, what's the sort of status of Catherine Chambers? Is she now engaging in treatments with Mr. Desmond?

A. I'm confusing a bit of the dates with Helen Boone and Catherine Chambers, but I believe that they initiated contact in November. I think my notes should clarify that.

Q. And you had said that during your absence, you had kind of left maybe a to-do list for Mr. Desmond and he hadn't

followed through on some of that?

A. Yes.

Q. When you followed up with him after your return, what was his ... Did he describe sort of how his situation was?

A. I think I recall he was, you know, not expressing being in distress and that he, like I said, he had misplaced a piece of paper and had followed up on, I think he was looking for a place to go work out, and a service that would, he can maybe ... Like not through VAC but through a different organization that they may provide funding for a gym membership but then he got discouraged when he saw the paperwork or something like that. So he spoke about that being important to him, that he wanted to go find a place to work out and I believe it was around that time that we said, Okay, well, what are we doing about the provider situation like, it's important that you have support.

Q. We can put up Exhibit 299 just because those are your notes and if you want to note what you were saying earlier about who was doing what.

A. Thank you.

Q. In terms of the recommendations from Ste. Anne's, what was it about Catherine Chambers that ... how did she get

involved?

A. Well, she ... What's that?

Q. In particular.

A. I don't remember if she was part of the first three names that I recommended or that I had searched for Mr. Desmond and they misplaced the paper. But I do know that she came recommended after the fact by Ms. Cross, who was the case manager in the area, and she confirmed that this was someone who had prior experience with veterans, was a qualified trauma therapist, and sort of was, you know, came recommended from a colleague. So I had no reason to doubt my colleague's judgement. She had been in the role for several years and so Catherine Chambers ... Essentially, what I normally do when I have options, so she provided two options, I probably said to the veteran, well, here are some new options and what do you want to do. Because we don't typically choose for. So when there was an agreement that we would connect with Ms. Chambers, I offered to check in to see if she had availability, if that could speed up the process. So that's how I first had contact with her.

Q. And she was available.

A. She was available and she was, you know, willing to

engage in a new veteran client and kind and very ... I don't know, I have nothing bad to say about Ms. Chambers. She was very pleasant.

Q. And just to kind of I guess summarize, you had talked to Ms. Chambers that Mr. Desmond would be reaching out. He didn't. So she contacted you about that.

A. Called me back.

Q. And then you contacted Mr. Desmond and then Mr. Desmond did contact Ms. Chambers and then services started after that.

A. Yes. If I can, I just want to, if it helps, not to cut you off, I'm sorry, providers like mental health providers in the community would not typically just reach out to a person, although I hadn't given her Mr. Desmond's name anyway. So it makes sense that she called me back, if you're wondering why she wouldn't have called the veteran. Like I hadn't provided his personal information. I was allowing for them to have contact. So I just wanted to make that detail clear.

Q. In terms of Mr. Desmond and Ms. Chambers starting that relationship, did you provide any documents to Ms. Chambers?

A. No, not right off the bat. I recall a conversation where I sort of, you know, asked how she wishes to proceed with

new clients. It's really not a case manager's place to tell a professional how to run their practice and I remember ... a detail that I remember speaking to her. Now I don't know if that was the first time we spoke or in a follow-up saying to her that we had recent assessments completed on file so if that was ever helpful to her, then she can definitely request and obtain the veteran's consent for some of that information to be shared. So there was never sort of any withholding of information but we don't just freely share things without the veteran's consent. So I believe in the end what happened was that she decided to meet the veteran and do her own sort of form of assessment and then would return with questions if there were any.

Q. And at the point where services stopped had she made any requests for documents?

A. Not at that point, no.

Q. And turning to the clinical care manager, Helen Boone, were you involved in the initial meeting with Ms. Boone and Mr. Desmond?

A. Yes, I believe I sort of helped facilitate the two of them having a telephone contact for their first appointment and then we agreed that I would join them for part of the meeting. So I think it was a telephone call while they were together with

me and, at that time, Mr. Desmond and I were able to say, because we had looked at some of the treatment recommendations and what he wanted to prioritize, so we were able to sort of share some of that information with her so that they could then sit together and say, okay, what's our first step and where do we want to go from here? So, yes, I believe there was that one conversation between the three of us.

Q. Do you remember any particular priorities that Mr. Desmond shared or conveyed to Ms. Boone?

(16:20)

A. I know it might seem silly but the gym thing really stands out for me. I think for him that was really important. He wanted to get more active and then I think by that time I would have informed her that there was a new provider for therapy that was just starting and I am very confident that I had told Ms. Boone that a neuropsychological assessment was recommended and we were going to have to find a provider to complete that. Now whether that was on Mr. Desmond's radar as a priority, I can't say for sure, but that was mentioned.

Q. So, in November then, Mr. Desmond was set up with Ms Boone and with Ms. Chambers. What was your sort of assessment of where things stood in terms of how he presented to you in

November?

A. Well, to me, there was, there were ups and downs, like in the discussions that we had had pretreatment and, similarly, there were ups and downs in some of the phone calls that we had post treatment. I think when the providers, the CCM, in particular, was finally in place, I was quite pleased. Like he engaged with her quite rapidly and so it was sort of end of November, early December would have been a positive, from my perspective and my understanding of where we were with the rehabilitation, would have been a positive sort of time because he was accessing local supports.

Q. I think there was some reference, just talking about some of the ups, that he had conveyed to you that he hadn't been drinking alcohol.

A. Sorry, can you repeat that?

Q. He hadn't been drinking alcohol?

A. Yes, he had mentioned to me that he had managed to stay sober since returning from treatment. So that would have been a very positive thing happening for him.

Q. Were you aware that in October or November, Mr. Desmond had visited St. Martha's emergency room?

A. I don't recall, no, exactly that he would have done

that, although I'm not ... well, I don't know why he visited but I'm not surprised because he had said that he felt that he could find a provider. Again, I'm thinking, I'm thinking psychother- ... sorry, psychiatry.

Q. Psychiatrist.

A. Now, yeah, I don't know that you do that necessarily by going to the emergency room, but I don't have the details.

Q. Okay. And the same question with respect to whether you're aware that he had been seeing some family physicians in the Guysborough area throughout the fall.

A. He didn't necessarily share that information. I don't know if those appointments would have been in any way related to his rehabilitation but, like I said, when he decided he didn't want to go to OSI, he had mentioned with a certain confidence that he was able to look for some professional supports in the area so ...

Q. So, from your perspective, and I guess this case and then other cases, but would you expect as a case manager that a veteran would keep you apprised of their visits to their family physician or emergency room physician?

A. It really depends on the nature of the visit. I mean certainly an emergency room visit is probably an important

detail to convey. Like I said earlier on today, we usually say to the veteran, any change in your health, any change as it relates to rehabilitation, of course, but I mean, obviously, veterans are going to go see their ... if they have a family doctor or they go into a walk-in clinic, they're going to see physicians for issues that I have no need to know about, right. So it can be whatever, a virus or anything, but some share more freely, so they will. And then, of course, I had cases where, yeah, they had an ongoing treating physician and they only share with me what they felt they wanted to share or was necessary.

Q. So, in this case, you don't have a recollection of being informed that Mr. Desmond's accessing services in the community.

A. No, not a recollection of that.

Q. Were you aware that he had missed a couple of appointments with Ms. Chambers?

A. I remember seeing that in the reports that she eventually submitted. I'm not sure that I had that information prior to, I can't recall for sure.

Q. She submitted her preliminary assessment after the tragedy.

A. Yes, because she, if my memory is correct, she had

seen him maybe three times in total, so it's not out of the ordinary that she would have completed a preliminary report after three sessions.

Q. So in December where he has a clinical care manager and he's receiving psychotherapy, what other things would you be looking at at that point on this particular case file?

A. Well, are you asking what I did or where sort of my mind was at with it?

Q. Where would the like the neuropsychological assessment or the functional assessments that were recommended by Ste. Anne's, were they still on your radar or where would they have been, keeping in mind that this isn't, from your perspective, this wasn't a frozen in time situation, so it was an ongoing situation.

A. Yeah. Well, of course, they were still on the radar and he is connected to providers now. So if we're able to make these, to find someone to do the neuropsychological assessment, and it was my hope that the CCM could help facilitate that, not only help in researching the provider but also, in my experience, a neuropsychological assessment is a pretty intensive process. Like I had one other veteran on my caseload participate in one and it was like an eight-hour assessment. So

having the CCM sort of help the veteran prepare for what that may involve, and then ... so, yes, so definitely still on the radar. Having the providers and the supports in place, however, you know, in my opinion, were a priority. But that's not to say that the rest wasn't important so ...

THE COURT: Ms. Grant, I'm gong to stop you there.

MS. GRANT: Okay.

THE COURT: Thank you. There is a matter that I have to attend to. So we're going to take a break. It's 4:30. We're going to take a break and come back at 6 o'clock.

Ms. Doucette, we're going to be a little later this evening and perhaps tomorrow evening as well, because I understand that everyone would like to hear your evidence and as soon as we can. So, if you could bear with us, we might take it a little later into the evening than we normally would but that's just the practical reality that we face here.

A. Okay, thanks for the heads up.

THE COURT: All right, thank you. So we'll see everyone back here at 6 o'clock then, thank you.

COURT RECESSED (16:30 hrs.)

COURT RESUMED (17:59 hrs.)

THE COURT: Everyone back? Thank you. Ms. Grant?

MS. GRANT: Thank you, Your Honour.

Good evening, Ms. Doucette. Can you hear me?

A. Good evening. Yes. Same?

Q. Yeah. So where we left off. We know that you didn't review sort of all the documents in this case but we did sort of mention earlier that Mr. Desmond had attended St. Martha's Hospital in October.

A. Mm-hmm.

Q. And you weren't aware of that. To your knowledge.

A. No, not specifically.

Q. Mr. Desmond had seen, and there was a report made by a Dr. Slayter who is a psychiatrist. And I guess I just want to ask you a question. He made a comment in his report that he thought that Mr. Desmond was falling through the cracks and had made some comments about that he was a veteran. And so my question to you is that, is there, in your experience as a case manager, is there maybe a misconception amongst people as to where a veteran would receive health care?

A. That's a good question. The misconception, perhaps. I remember examples of veterans having been gently turned away from community mental health services - that was in New Brunswick, of course - on the basis that, you know, they were a

veteran and could, therefore, access different treatment, which is, you know, depending how you look at it, partly true. Some veterans have, you know, A-line coverage and are able to access private therapy. So that would be a difference from accessing like a community mental health resource.

That said, veterans are members of the civilian population just like the rest of us, and when it comes to accessing services of a physician, it's no different than for you and I. In fact, I remember many veterans sort of being surprised by the fact that when they were released from the Forces they now had to look for a family physician because that was such a different reality than what they had known before.

So on the provider side, I guess I wouldn't be surprised if, yes, some health care providers believe that there is a distinct system for the veteran population. And perhaps because of the OSI Clinic network, which works very closely with veterans, but I believe maybe a few other clientele. But, essentially, it's still part of the provincial health authorities or connected to the provincial health authorities. So, yeah. I think it's fair to say that there can be misconceptions.

THE COURT: I'm going to stop everyone just for a

second.

MS. GRANT: Mm-hmm.

THE COURT: Ms. Grant, I have this to say. We heard Dr. Slayter's evidence. We've read Dr. Slayter's report. We're aware that he made a comment about, in relation to, Cpl. Desmond falling through the cracks. And to suggest that there are misconceptions in the public and to suggest that Dr. Slayter is under some kind of a misconception in relation to his commentary in that report, I don't accept that the premise, for a start, in relation to the question. Do you expect this witness to provide any commentary in relation to Dr. Slayter's comments? I expect you to put the report to the witness, have the witness read it, and have the witness identify where she believes Dr. Slayter is under some misconception leading to his commentary with respect to falling through the cracks.

MS. GRANT: Thank you, Your Honour.

THE COURT: So I invite you to proceed with it that way if you choose to pursue the matter.

MS. GRANT: No, that's fine.

THE COURT: Thank you.

MS. GRANT: Ms. Doucette, can you tell us about a time where you were vacationing in Nova Scotia and you contacted Mr.

Desmond?

A. There was a time in, I believe, November 2016, where I was going to spend a long weekend in the area, so I had mentioned in passing to him that I would be in the area if ever he felt that having a face-to-face meeting would be helpful, that there may be a possibility of arranging it like the following week when I was headed back. But that never took place. It was just sort of a - If you feel that it would be helpful for you. And so that was the extent of that.

Q. Okay. So I want to turn to sort of the more events of January 2nd and 3rd. In your words, what transpired with ... You can start with Ms. Boone.

A. Okay. Well, a contact that I had with Ms. Boone in early January followed a call that I received from a VSTM from the Halifax office sort of inquiring about a client. She was made aware that I had a client in the Province of Nova Scotia and she was aware that a tragedy had occurred and had some information as to sort of who the veteran might be, so was just trying to piece together who may be connected to this person.

So we just had a brief chat, you know, very sort of caring, and nothing was confirmed. So in order to obtain more information, we determined that maybe connecting with Ms. Boone

would be something that I could do to see if she had heard of anything, where she's, you know, not right in the same location, but in the region. So that's when I contacted her and asked if she had heard of anything, which I don't believe she was aware. And so I just, you know, gently mentioned to her that there were concerns that maybe the veteran had been involved in a tragedy, so we agreed to keep each other posted.

That was January 4th, so I'm not sure if that's exactly what you're referring to, but then, and the news were confirmed and it's sort of after that that I sort of received more of the details of the involvement that Ms. Boone had had with him.

Now, do you want me to speak to Ms. Chambers?

Q. Sure.

A. So, on January 3rd, in the afternoon, I had received a call from Ms. Chambers, sort of a, I received it sort of as a courtesy call - Just wanted to let you know that the veteran had reached out and that there's, you know, a change in plans. He's going to be looking for a place of his own. And so I just asked about details of his contact and she described the interaction that she had had with him, the safety plan that they had discussed, and the plans to follow up, I think it was within two or three days and that he had, I believe, also mentioned plans

to connect with Ms. Boone shortly thereafter too.

So she offered that she simply wanted to keep me in the loop and I thanked her for that and I told her that I would try to be in contact with the veteran as soon as possible.

That said, there was nothing about what she was telling me that was expressing a great emergency, sense of emergency. She had, you know, asked the questions that a professional would normally ask to make sure that the person was okay, and, What would you do if you start to feel like your safety is at risk? That sort of stuff, so ... and I believe that that's all recorded, what she had done.

So, from my perspective, it was, okay, change in circumstances. Normally, the veteran would report that stuff themselves but she did it that time.

(18:10)

And so the rest of the day, I was in the veteran's file for a little bit and then received back-to-back calls. And, at the end of the work day, went home with a plan to call him first thing in the morning just to check in and say, you know, I heard that there's a change of plans. Do you want to talk about where you're at with that? And, unfortunately, you know as well as I do that the events transpired that evening so ...

Q. On the 3rd.

A. Yes.

Q. And can you tell us about your experience the next day on the 4th?

A. The 4th was a particular day. There was a snowstorm in New Brunswick that day and our office delayed opening by like a few hours. So I got there later than usual but still a bit early, because I live not too far from the office and I was ... started the day off in Mr. Desmond's file like I had planned to do. Was looking at the case plan and what needed to be updated with the intention of giving him a call. And then the call from the Halifax VSTM came that morning around, I don't know exactly, it must've been sometime around 10 a.m.

Q. And what happened after that? Did you speak with Ms. Chambers?

A. I spoke first with Ms. Boone, as I mentioned earlier because we thought maybe ... I thought maybe she would've received information, and the VSTM who contacted me had said, you know, Let's keep each other posted. I think she was pretty certain of the information that she had, but wasn't in a position to confirm it, and that wasn't her role, but she just wanted to make sure, also, that I had support in the office if I

needed it. That sort of stuff. Like just in a very caring manner.

And then so I contacted Ms. Boone. She said, Well, let me see if I can find anything out. Like without putting any added pressure on her, I just said, you know, I know this is, you know, potentially very tragic news, so just call me back but don't feel like you have to go out of your way to.

And then event- ... I don't remember exactly ... Yeah. There was a message, an email message, that came through from the manager within New Brunswick that sort of provided more information. So I grew kind of more concerned that, okay, this is really him and his family, and I was in a bit of a shock. It wasn't really a good day by any means. I ...

From there, a manager arrived at the office. Like I had mentioned, it had opened late and people who were travelling from far away were sort of trickling in late, so connected with a colleague and the manager to explain what was going on, and it was kind of hard to contain the emotion. And so we had to sort of wait until, I think, noon, there was a press conference from the RCMP that would confirm the names of the deceased. So when that came out then I received confirmation that it was Mr. Desmond and his family.

And then calls started coming in. I wasn't sitting at my desk, though, so they were going to voicemail. So I checked my voicemail and there was a message from Ms. Chambers who had heard from another person. I believe it was a VAC colleague. I'm not sure. And so I called her back and we chatted about, you know, the conversation we had the day before. I was, you know, in many ways reassuring her that I had not, from her call, understood that there was this amount of, like this imminent risk, and that I felt that she had done her job really well.

And so ... and then there were calls that came from OSI New Brunswick. It was a bit of a, a lot of people checking in, and some with really good intentions. Some, I don't know, just not really sure what to do.

So that was the 4th. And so I didn't really focus on anything else that day and I came back to the office the next morning and trying to figure out, you know, what was going to happen over the course of the next few days because it was such an exceptional event. And I'm not sure exactly when, but there was ... it was probably on the Thursday that a request from the Deputy Minister's office came to sort of have an overview of my involvement in the case. There was not ... it came through my area director and there was not a whole lot of guidelines as to

what they were looking for, so I just sat down in an office and wrote down that chronology of events that you now have, sort of month by month, my involvement, and tried to keep it to the important details.

And, amidst that there was ... I reached out to one of our COs because I had never, at that point, had anybody pass away on my caseload and I, you know, needed to figure out different things that I should be doing/not doing. So none of it was super clear but that was essentially the rest of the week.

Q. And just to be clear on the record that what you produced and provided in response to that request is Exhibit 299, what we've been looking at, your notes?

A. Yes. The one that had the different colour inks.

Q. Okay. And, after, there were also some issues where like Ms. Boone and Ms. Chambers then sort of subsequently provided their reports or documents?

A. Yes. So I believe it was me who told them that, you know, when you have a chance, then you can complete those and turn them in. Obviously, we didn't expect those to arrive the next day. Like they were also impacted by this. So we knew they were coming and they arrived sometime in the month of January.

And I'm trying to think of other details from that week. Just we were, from talking to them, were able to sort of piece together that he had been in contact with both Ms. Boone and Ms. Chambers which, to me, was a positive reflex. He was reaching out to his providers and, however, somewhere along the lines, did not convey exactly what was going through his mind or things shifted very quickly. That's not the sort of stuff that we're able to predict or ...

Q. Thanks.

So I just wanted to turn to some other scenes. There's terms of reference in the Inquiry and some things that didn't fit in, sort of, to our chronology.

Did Mr. Desmond ever talk to you, to your recollection, about head injuries?

A. Not that I recall. Like I mentioned earlier, back injury was something that came up at the time of assessment and a few times during case management process. I don't specifically remember him telling me about a head injury.

(18:20)

Q. We did talk about back pain.

A. Yes.

Q. And some other issues. One of the other terms of

reference in the Inquiry relates to firearms, so I just wanted to ask if Mr. Desmond ever mentioned having or using firearms other than what we already discussed, which was that incident in November 2015?

A. No. I remembered that incident, and when he spoke of the firearms, he had specified that it was hunting equipment.

Q. And with the issue of sort of medical records, can you explain, in your own words, sort of what VAC's role is as, you know, with respect to medical records of a person that is on your caseload? That's not a very helpful question but in terms of VAC not being a health care provider. So it's not like a doctor's office.

A. Yeah. No. No. So I don't consider or understand VAC to be sort of a keeper of medical information. Like it's not a place where everything gets turned over. Some medical information or psychological information will come to us by way of program participation or, like in the rehab programs, for example, which is what I'm most familiar with, we will have summary reports, recommendations from professionals. That sort of stuff. And that goes on their file but it's not ... like, one, it's not information that belongs to me as a case manager or a VAC employee. It's really evidence on the veteran's file.

And they, obviously, like any people in a ... any one of us can, can access this information through access to information ... I forget what it's called. Like the ATIP and privacy laws.

And they're aware of that generally, that if they ever want to access something on their file, that there's a process that they can go through to obtain that. And it's happened before. I've had some veterans request some aspects of their file.

But, yeah. Not a keeper of medical records by any means. And there were records that we talked about, "need to know", I think earlier on today, and there were records on file that could've been a medical nature that I had no, even as a VAC employee, like I do not access those.

Q. Would it be ... you talked about getting summaries. What about sort of a psychologist's file with notes of sessions? Is that something that you would ever see or come across?

A. No. I mean each provider obviously writes differently or can structure their report in their own style, but if you have seen any of our resource screens, we normally would authorize, in rehabilitation anyway, a number of sessions with a provider and the cost of one report, for example. So the purpose of that is so that we can sort of be updated on any progress, you know, where is it going? Does a provider

recommend that the resource be renewed? But not every detail of their therapeutic exchanges are shared with us, nor should they be. Again, that would be like a "need to know".

Q. If a veteran were to ask you for assistance with getting records through you or a clinical care manager, is that something you would endeavour to assist with to the extent you can?

A. As a clinical care manager or a case manager?

Q. Yeah.

A. I don't think that there's really much in my power that I could do as a case manager. Generally, if a veteran was looking to access their CAF records, what I could do is sort of point them in the direction of - This is, you know, who you can call and how you can word your request if you put it in writing. Or that sort of stuff. But I don't have any sort of privileged access to any of these things so ...

And, generally, veterans, like any other civilians, access their own medical information. If someone is going to access it on their behalf, there would have to be very clear documentation and consents on provided to whomever is providing those records, so ...

Q. So a consent form, the niche of the information and

who it's going to? That kind of a ...

A. Yeah. Yeah. But it's definitely ... I'm trying to think of times when, if I was ever involved in a veteran's efforts to access, and the only thing that really comes to me is just sort of pointing them in the direction if they're ... if they bring it up to me and they don't know where to go.

But, more and more, you're seeing veterans leaving the Forces with that request already in. And then they would share that their records would arrive to them on like a disc. And then they could choose to hand it over to their physician if they wanted to. It was often the treating physician that would've been interested in those documents if they're helping the veteran with different kinds of applications and ...

Q. So if a family member called you and was looking for information, what would you do in that situation?

A. Well, the first step is to ... I'm not legally allowed to divulge any information, whether you're a family member, or a friend, or even a professional, unless there is, again, very clear documentation on file.

So there was a place in CSDN, our system, where we could check very rapidly if there was such a thing as an authorized third party on the file. So if that was there and the person

was identified and the caller could confirm their identity, then yes. But, I'd say, in most of the cases that I've worked with, there wasn't such a person. Like some veterans would have their family more involved than Mr. Desmond, but to have someone who is authorized to just freely speak on their behalf and receive information, not as common, in my experience.

Q. In terms of your time as a case manager, 2015 to 2018, do you have a ballpark guess of how many cases you might've dealt with as a case manager?

A. Total?

Q. Yeah.

A. No. Well, I should say that my caseload, like I said, would've been somewhere around 35, 40, but that's not counting all the decisions rendered, rehabilitation, all the veterans that I would've supported through intake. And sometimes an intake matter could, you know, go over several days. So I really can't give you a clear number outside of what my caseload would've been. And that, you know, based on what I've observed around me, that was, the caseload was, constantly growing, at least in the New Brunswick office. So there are case managers whose case load grew even further than that so ...

Q. This is, I guess, a bit of a subjective question, but

in terms of the cases that you case-managed, would you say that Mr. Desmond's was the most complex file that you encountered?

(18:30)

A. Not the most complex, no. It certainly had its complexities. I'm not minimizing sort of any of the needs, but I can think of a few with whom engagement was very tricky. Each call was very challenging, were some who felt the need to call almost daily because of so many needs and a different level of disorganization if I can put it that way, without disrespect.

Q. You've obviously had some time to reflect on these events and part of this exercise is to hope that this type of tragedy can be prevented in the future.

A. Yeah.

Q. Is there anything, you know, in hindsight or retrospect that you think you might have done differently or, you know, with this sort of lens of hindsight? Do you have any thoughts to share?

A. Yeah. I certainly don't think I was perfect in any way. I don't think it is possible to be perfect in this job. That said, I do want to say that with the time that I had to dedicate to the case and the other demands, I'm not sure that there is much more I could have done in terms of preventing

this.

I, obviously, did not have all of the information regarding what was happening in the marital relationship; however, one thing that I can tell you that has changed for me, so that's kind of a hindsight, is I definitely have no hesitation now in asking more direct questions about if someone is reporting with me conflict in their marital relationship or I have ... I can much more easily ... not that I was preventing myself from going there, but the reflex wasn't the same, I guess, asking about a history of violence between intimate partners, that sort of stuff. So that's something I say I've probably changed a little bit as a result of this tragedy.

Q. Is there anything else that you feel like we should know or would be helpful for everyone to know about the work that case managers do on a daily basis for a veteran?

A. It's a question that's hard to answer without sounding like I'm complaining. I'm really not complaining. But it's a job where ... it's a job that really dispels the age-old myth that public servants are "lazy" or have a lot of time on their hands. There is constant demand, constant requests from the veterans but also from providers, from management. Like there is always, always something to do. And so in that sense, I

would say it's a quite demanding job.

And case managers are all professionals who have a degree and prior experience. I have never, in the years that I was there, met a case manager who arrived in their role fresh out of school. There's usually a previous experience managing either a client caseload or working with a vulnerable client. So they're selected carefully. I say "they", because I am no longer a case manager. But my observations and the people that I had as colleagues, I can tell you that you don't do that job if you don't believe in rehabilitation potential and that veterans are capable of succeeding in their transition.

They generally are rooting for the veterans, want them to succeed, tend to ... you know, there's err on the side of the veteran a lot. It's not ... there's no one there trying to prevent anybody from progressing. I have not met any case manager who doesn't work hard for their client. That said, I am not the spokesperson for case managers.

But I guess I'm pleased that you asked that question because, you know, we don't often hear good press about Veterans Affairs, but I can tell you that I've met some phenomenal workers there and I know some that still work there and just really believe in their mission and put in the extra time and

effort.

Q. Thank you, Ms. Doucette. Those are all of my questions at this time.

A. Thank you.

Q. There'll be other questions momentarily.

A. Thank you.

THE COURT: Thank you, Ms. Grant.

Now I know that Mr. Russell has some questions and I know that he is going to be lengthy. And so I might canvass some of the other counsel to see if they have some questions that might be less lengthy.

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

THE COURT: Thank you. Mr. Macdonald?

MR. MACDONALD: Oh, Your Honour, on my worst day I'll be shorter than my friend, Mr. Russell. I'm teasing him, Your Honour. An hour or less, and maybe half that.

THE COURT: Okay. Mr. Rogers? Sorry. Mr. Rory Rogers? Rory Rogers.

MR. RODGERS: Sorry, Your Honour. I forgot he was there.

MR. ROGERS: Yeah. At the moment, Your Honour, we anticipate no questions but if Mr. Russell's ...

THE COURT: No, I appreciate that.

DISCUSSION

MR. ROGERS: ... questions ... yeah.

THE COURT: I'll canvass you ...

MR. ROGERS: But at the moment ...

THE COURT: I'll ...

MR. ROGERS: ... nothing.

THE COURT: This is not your last chance. I'm just trying to see how we can best utilize our time this evening. Ms. Miller?

MS. MILLER: I will have questions, Your Honour. I had anticipated reorganizing some things after this ...

THE COURT: Okay.

MS. MILLER: ... today's evidence and I was going to do that tonight and tomorrow. So I'm happy if Mr. Russell goes ahead of me.

THE COURT: All right. Thank you. Ms. MacGregor?

MS. MACGREGOR: No, Your Honour. We don't have any questions.

THE COURT: All right. So Mr. Macdonald, are you content to ask your questions now? And what I will do, if you do, rather than break Mr. Russell up, if there's something that you want to revisit after, I'll give you that opportunity.

MR. MACDONALD: I'm content to ask them now, Your Honour.

THE COURT: All right. Fine. So I think what we'll do, we'll hear from Mr. Macdonald now rather than have Mr. Russell start and break that up. So, Ms. Doucette, we're going to ... Mr. Macdonald has some questions for you. Thank you.

MS. DOUCETTE: Okay. Thank you.

CROSS-EXAMINATION BY MR. MACDONALD

(18:38)

MR. MACDONALD: I was going to say good afternoon, Ms. Doucette, but good evening I guess now is more appropriate. I'm Thomas Macdonald ...

A. Good evening.

Q. ... and I'm the lawyer for Ricky and Thelma Borden, the parents of Shanna Desmond, the grandparents of Aaliyah Desmond, also the lawyer for their son, Sheldon, who was Aaliyah's uncle, and share with Ms. Miller co-counsel for Aaliyah.

A. Okay.

Q. So I wanted to just start ... I think if we could look at ... bring up Exhibit 117, please. Can you see that okay, Ms. Doucette?

A. Now I can. Yes.

Q. Sure. Now you've seen this before. This is a case plan and these are your notes. You developed this plan?

A. Yes.

(18:40)

Q. Yes. I want to focus on the first page, the first paragraph, "Overview of the Situation", and just that first paragraph that is under "Overview of the Situation". Do you need a moment to refresh your memory to look at that or shall I go ahead?

A. Yeah. I would appreciate that. Thank you.

Q. Sure. You let me know when you're ready.

A. Okay.

Okay.

Q. Okay.

A. Thank you.

Q. This is the starting point really in terms of a note form of your working relationship as a case manager for Mr. Desmond, isn't it? This is the beginning, your assessment of the situation? Is that fair?

A. Yes and no in the sense that I would have had prior conversations with him. And there were some notes, as we saw earlier today, elsewhere in CSDN. But this would be following

the assessment, yes, the first sort of narrative to build a case plan.

Q. Right. Now I'm just going to refer to certain parts of this. So I'm beginning ... it's all in this paragraph. And so three lines from the top: "In particular, the veteran reports great difficulty to controlling his emotions and his generally heightened anxiety often leads to or at least places him at ongoing risk of anger outbursts or panic attacks."

Then it goes on: "The veteran also reports difficulties in his marriage of ten years, (e.g., poor communication, conflict)." And it continues. And then down about another four lines there's a sentence that reads, in part: "The veteran currently presents as lacking the ability to cope with his emotional turmoil ..." and it goes on. And down another couple of lines there's a couple more sentences: "The veteran has proven he is open to receiving psychological help. The mental health professionals he has connected with report an inability to begin working through his military-related trauma due to ongoing instability; i.e., disabling symptoms of PTSD."

So is it fair to say, from at least on January 27th, 2016 when you made the note, you knew that background for Lionel Desmond. You knew this was part of his profile, his package,

his picture, if I can put it that way, didn't you?

A. Well, yes. I wrote that, so, yes.

Q. Sure. When you spoke to Catherine Chambers to engage her services to reach out, would you have made her aware of any of these specific factors that I just read that are in this paragraph?

A. Not upon first contact, no. As I explained before, I contacted Catherine Chambers after the veteran had not followed through on the different options that were presented to him. So I was doing that sort of as a way to help speed up the process of connecting to a resource. So I didn't have any consent in my possession to be able to freely disclose information. So when I contacted her the first time, it was really about, Do you have availability to work with a veteran, a client who is a veteran, and could I put someone in touch with you? So, no, I did not disclose that upon first contacting her.

Q. So are you of the view that a lack of consent would have prevented you from never mentioning his name but saying, There's a perspective of that client that may be referred to you and that client's symptoms, for lack of a better word are and then summarizing what's in this paragraph? Could you have done that, do you feel?

A. Could I have done that? Potentially. I guess the provider ... we had just agreed that she was going to connect with the veteran and start the process of working with him. So there was the option, after the first session, the second session, whenever she wanted, with the veteran to say, Okay, well, maybe it would be helpful if we obtained more information from. I did make her aware that we had recent assessments available if she ... so I'm not sure ... I ... it would be atypical of me to reach out to a professional and provide a whole lot of information before the veteran ever sets foot in her office.

Q. Right. But today you're not aware of any, and I know sometimes I've used the word "barrier", but you're not aware of any VAC policy or barrier that would have prevented you from giving that overview to her on the phone that day. Didn't need consent had you perhaps decided to do that, to disclose that overview without giving his name but just giving a background of symptoms. You could have possibly done that, could you not?

A. I certainly would not have presented that paragraph with just the names out because there is information there that could have potentially ... I don't know. This person works in the community. There may be a way that she could have made a

link. So it's more ... it's not necessarily a VAC policy, it's more on the basis of confidentiality that I wouldn't have provided that right from the get-go.

Q. So when you say ...

A. But there was no ...

Q. Sorry. Go ahead.

A. There was no intention to keep information from a provider if the provider felt that that was necessary in order to do her job.

Q. Sure. And I'm not suggesting you were intentionally keeping anything. But when you speak of no VAC policy, but you spoke of confidentiality, was that a subjective determination you made? It wasn't a VAC policy to say that you can't, when setting up a provider, outline some factors to the potential client the provider will counsel. There is nothing to stop that, was there?

A. Well, I don't know of a specific policy. But when I say it's not a specific VAC policy, I mean that it's sort of broader than VAC, that when we work with clients in a professional capacity, we have to be very careful about the details that we share. There was a potential that Lionel Desmond would have changed his mind and decided not to work with

this person. So I'm not ... you know what I mean? I'm not in a position to just be providing information freely.

Q. Right. But she knows you're referring a veteran. She knows likely that that veteran was in military service, may have had some issues or she wouldn't be required to be counseling. So aren't there some ... is there not a checklist, but are there basic factors that you or other case managers at VAC would have, in that initial call or subsequent call to a third-party provider, given a little detail in terms of they know who it is, without the name, who's going to be walking through the door, potentially a person with these kinds of psychological issues that have been identified by previous treatment providers, medical professionals, et cetera.

A. Well, it is possible that I gave her tidbits of information. But if you're asking me about the specific paragraph ...

Q. Yeah.

A. I don't think I would have provided that.

Q. Okay. Do you remember what tidbits, is that the word you used, of information you would have given her?

A. There is a note in my case plan, I believe, that reflects a conversation that I had with Catherine Chambers. I

am not sure if it would capture every single thing that I said but it could perhaps refresh my memory.

Q. But other than what's in the note, do you have any independent recollection of anything else you may have provided to her in that call?

(18:50)

A. Like I said, I recall telling her that we had recent assessments on file, if that could be of assistance to her, and that I was going to ask the veteran to be in touch with her as soon as possible so that they could initiate the work. I already understood, and she confirmed, that she had done work with veterans in the past and that she was certified to treat occupational stress injuries so ...

Q. Do you recall, in your conversations with her, her ever expressing to you any reluctance to take on this assignment of Mr. Desmond or because of ...

A. No.

Q. ... qualifications or lack of experience on her part?

A. No, none whatsoever.

Q. I know, and I'm going to just touch on a couple of areas Ms. Grant took you through. The clinical care manager, so we know that Lionel Desmond left Ste. Anne's in August of 2016

and we know Ms. Boone, it was later in the fall of 2016 when she was put in place. So there's a time ... I'll call it a "gap" ...

A. Yeah.

Q. ... but I'm not asking you to agree with me but a gap.

A. Okay.

Q. What do you say, this evening, is a reason for that gap? Why did it take between August and the fall to line up the person who turned out to be the ... (inaudible - audio)

A. I can explain to you what caused the ...

Q. Sure.

A. Today what caused the delay.

Q. Yeah. Would you do that?

A. But I also have ... yeah. I just wanted to point out that I also, in the notes that I prepared post-tragedy, have made a comment about that.

Q. Yes.

A. So ... and that was, you know, two or three days after.

Q. Right.

A. So it wasn't an oversight on my part. So essentially when a clinical care manager registers to work with veterans,

they register with Medavie Blue Cross. So we can go on that platform to search providers. In this particular case, when I search a provider for Mr. Desmond, there weren't very many options, and I would say probably based on the geographical nature. He was living in a more rural area. So we didn't really have a pool of candidates registered.

Helen Boone was the person that I was able to find who was the closest and willing to engage. However, where her services had not yet been enlisted, I don't know if that's the right word, sorry, but by VAC, there was a step in her registration that was not complete. So she was registered with Medavie, but there was this training, BHSOL, system, which we mentioned, that needed to take place because it was the first veteran that she would be assisting in the capacity of a clinical care manager. And that training is not scheduled weekly is what I understand now. I don't know the schedule of training. It's organized through head office. And obviously took more time to organize than I, myself, thought would take.

So we prepared the registration paperwork that she needed to prepare in order to register for this training and then the first date of training, if my memory is clear and the records are accurate, would have been October 27th. So it took a number

of weeks before she was able to sit down and do the training.

Q. Okay. So we know also in August of 2016 you had the telephone conference, as he was leaving Ste. Anne's, with the Ste. Anne's treatment providers on that call. And I'll just summarize it. From my view, what jumps out at me is they identified these neurological issues and thought that a neuropsychological evaluation should be done. We know it was not done, you know, up until the time of the tragic incident. Can you explain why it wasn't done before January of 2017?

A. Yes, I can explain. And the simplest way I can explain that is there were multiple things that needed to be put into place and services and supports. And there was, based on the first inquiries that I made, no one in my contacts who could identify a psychologist who is specialized because not every psychologist conducts neuropsychological assessments. It's a very specialized field. So there wasn't a provider readily available. We had to go searching for that as we were also trying to set up other services.

So it was a question of prioritizing what might be most helpful at that moment in the situation we were in. So it wasn't a question of we're ignoring this. It was a question of this is one recommendation among others that we plan to get to.

And, unfortunately, it wasn't completed before January.

Q. Did you reach out to Halifax for a provider there for this neuropsychological assessment?

A. I believe I mentioned it in my conversations with like a manager there. That said, I didn't go into an in-depth search of providers in the Halifax area as I was focusing on trying to get other services set up. And no disrespect to Mr. Desmond, but he'd also made it clear that he wasn't interested to travel to Halifax to obtain services. So I'm not saying that it wouldn't have happened down the road but there was other things that got prioritized.

Q. So in August of 2016 when Lionel was being released from Ste. Anne's, for you, bracket Ms. Doucette/VAC, what did you see at that point as the main priority for Lionel that could be provided by you and VAC? So if there's a hierarchy of needs what was number one?.

A. Well, I don't ... I wouldn't call it a "hierarchy of needs". I would call it out of the ordinary circumstances where a person is coming out of treatment with a number of recommendations but doesn't have in place the professional support that they normally would.

So, to me, and to the people around the table, the resource

of a CCM was an important priority because it was anticipated that that would help us set things up for Mr. Desmond in his new place of residence. I understand that we are later now and when we look at it that may not be exactly what happened, but the neuropsych assessment, I'm not saying that it was at the bottom of the list. I'm saying it was an assessment. It's a very specific sort of assessment and would have likely been helpful, provided more information, but having providers and people to work with Mr. Desmond on an ongoing basis, to me, was important ... as important.

Q. So of course VAC, and if you think I'm putting this unfairly, tell me. VAC was instrumental in helping get Mr. Desmond to Ste. Anne's, Dr. Murgatroyd ...

A. Uh-huh.

Q. You. So he was there for a number of months, as we know, culminating in this pre-release telephone conference. During all of that time, I mean surely as the case manager you would know that he's going to be released at some point and will require services, whatever they may be.

(19:00)

A. Uh-huh.

Q. So it wouldn't have been that unusual of a

circumstance that a person, a military veteran coming out of Ste. Anne's, who is being case managed by VAC, would require services after the months he spent at Ste. Anne's when he gets out of Ste. Anne's. That's not unusual, is it?

A. No, but that's not exactly what I said. What I said was unusual about the situation is that normally when a person is released from inpatient treatment, they go back to a team of professional providers who are already assigned to them, people who like Dr. Murgatroyd would have been in a position to receive a neuropsychological assessment and see if there was any information in there that could help him move forward with therapy, for example, just as an example. I also want to point out that Dr. Murgatroyd is not an employee of Veterans Affairs but of OSI New Brunswick at the time.

Q. Sure. And I know that. I didn't suggest that, did I? You didn't take that that I thought he was a VAC employee? I didn't mean to ...

A. I thought you said that but ...

Q. No, I didn't.

A. ... it's okay.

Q. He's just part of the team, right, the early team with Mr. Desmond. He wrote a letter to get Mr. Desmond into OSI ...

A. Yeah.

Q. Into Ste. Anne's. Sorry. Let's turn to Exhibit ... if we could have 299, please, and page 7. When it comes up, Ms. Doucette, this will be the review you did, I guess, based on your evidence after the chronology you did when the Deputy Minister's office reached out.

A. Yes. Sure. I can see it.

Q. Okay. Perfect. So page seven. And I'm looking at the top part of the page and the part that's in yellow in my copy. I'll read it: "Significant bureaucratic barriers complicated the process to have CCM services started. CM would like to discuss with decision-makers at some point if at all possible."

And that sentence, I left out, inadvertently, is proceeded by four stars. So you wrote it, I guess ... are the four stars ... is that meant to signify this is an important sentence to the reader?

A. That is what I was referring to earlier on when you ... when I said that I wrote about this in this case, following the tragedy. So, yes, stars to say I personally as ... not VAC, but as an individual working within VAC, thought that the delay were a bit ... well, exactly what the sentence says. So that

there were significant bureaucratic barriers and it complicated the process to have CCM services started and that I would have liked an opportunity to talk to decision-makers about this. Keep in mind, Mr. Macdonald, I am writing this two days after the tragedy. I don't take back what I wrote. I meant it.

Q. Well, that's important and I appreciate you mentioning that. I want to parse the sentence a little bit. Let's start with the first one. What are the significant bureaucratic barriers? Specify them for me. Break them out, please.

A. So the bureaucratic barriers for me, are I, as a case manager, would have obviously appreciated being able to go into the Medavie Blue Cross system and find a CCM, clinical care manager, like I did, found Mrs. Boone, and then have her, you know, ready to go within a span of a few weeks as opposed to several weeks, as we saw.

I guess I didn't understand, at the time, that these (sic) training didn't happen as often or as easily, sorry, as I thought that they might be able to. So that was part of what I would have liked to know. Why would it take this much time to have a person sit through this training, a training that I've done myself so I'm familiar with it.

So the bureaucratic barriers were (a) that training and

like I mentioned in speaking with Ms. Grant earlier, once the training was completed, then we were told, well, there was another step because there was this form that was never filled out, and it was. It had been done and ... I mean, so to me that's ... to me, as an individual, I'm not speaking necessarily on VAC's behalf. I'm speaking of my opinion as a case manager in that situation. That was bureaucratic barriers.

Q. Can you think of any other bureaucratic barriers you may have meant other than what you've told us so far?

A. Specific to the CCM services?

Q. Specific to the Lionel Desmond case and what caused you to write this overview.

A. Well, what caused me to write the overview was ...

Q. No, no, not what caused you. I'm sorry. Maybe you misunderstood my question. Other than the barriers you've just told me about, are there any other barriers relating to the Desmond case that you can identify today under the heading "bureaucratic barriers"?

A. That's a pretty big question. I think if there had been others that I felt very strongly about, that I would have noted them at that time in the same way that I noted them here. My whole intention when I prepared this report was to be as

transparent as possible with my involvement in this case. I was not wanting to leave any details behind. So I would say those are the ones that I felt strongly about.

Q. Okay. And are there any new ones since, now we're four years beyond, when you would have written this that you can identify for us today or does that cover it?

A. Bureaucratic barriers?

Q. Yes. With respect to VAC and with respect to the Desmond case.

A. It's an interesting question. I'd probably need a little bit of time to think about it, if that's possible.

Q. Yes. Take your time.

A. Umm ...

THE COURT: What I might suggest, Mr. Macdonald, is appreciating that Ms. Doucette might want to think about it more than the couple of minutes that we might have here, I would allow, if you're agreeable to it, to leave the question with Ms. Doucette and then when we return tomorrow morning, for instance, would you be content to return and ask her if she's had an opportunity to consider it overnight?

MR. MACDONALD: Perfectly content, Your Honour. And, in fact, if she even wants to discuss that with her counsel, that's

fine by me. If counsel advises you tomorrow morning that she can't think of anything else or if she has a list, then you can let me know and I won't need to ask her any more questions or will, depending upon what the answer is.

THE COURT: So would that help, Ms. Doucette, if you ... appreciate that you'd be off camera and have an opportunity to, on your own time, just think about it and again we ...

MS. DOUCETTE: Yeah.

THE COURT: ... return ...

MS. DOUCETTE: Yeah. I'm certainly willing to give it some thought. Would it be okay if I wrote the question down?

THE COURT: Yes, absolutely.

MS. DOUCETTE: Okay. Can ...

MR. MACDONALD: Sorry. Go ahead.

A. Would it be possible to just repeat your question, Mr. Macdonald, to make sure I'm reflecting on exactly what it is?

Q. Yes. Of course. And because we're on the record, I'm just going to go back into it in a little bit of detail. So we were looking at Exhibit 299, page 7, the sentence with the four stars on the top one-third of the page. The first sentence reads, four stars: "Significant bureaucratic barriers complicated the process to have CCM services started."

And I've asked you about bureaucratic barriers. You've answered me, as I understand it, in relation to at the time you wrote this, which was at the request of the Deputy Minister's Office, this chronology, and you outlined that. And my question to you was, now, four years later, and I'll add this, obviously you've been thinking about this probably for four years to some degree or another, human nature. I'm wondering if you can identify any new ones that you've thought about since the day you wrote this four years ago and today or, in this case, tomorrow morning.

(19:10)

A. Specific to the Lionel Desmond case.

Q. To the Lionel Desmond case. Yes. Or if there are barriers because you've been working at VAC, I know not since 2018, if you think it will be helpful to the Inquiry, if there are other barriers that you'd like to outline that may not be related to the Desmond case, I'm sure ... can't speak for Judge Zimmer, but he might appreciate that if you turned your mind to it, if you feel so inclined.

A. Thank you for repeating the question.

Q. Okay. Sure. Now the second sentence says: "CM would like to discuss with decision-makes at some point, if at all

possible." Did you ever discuss the situation with any decision-makers at VAC or anywhere else that you're aware of?

A. That specific point, no, not that I recall.

Q. Now obviously other eyes other than yours and mine and all the people in the room here who would have read this, did anyone at VAC ever reach out to you about that second sentence and say, We understand you'd like to speak with decision-makers and come on in for a talk. Anyone ...

A. Not specifically in reference to that sentence. I did have some people at VAC in higher positions, if I can put it that way, who have, however, reached out and taken the time to discuss.

Q. Okay. Who is the person and what is their title at the highest level that would have reached out to you in VAC?

A. Okay. Shortly after the tragedy, there was a conversation with Mme Charlotte Bastien, who was then acting ... I'm trying to get the title right. No, not "acting". Sorry. Mme Charlotte Bastien who was our national director of field operations. So, essentially, she was responsible for all of the services to veterans across the country, like the different teams. She's still in the organization in a different capacity, I believe. And at another ...

Q. Could you spell her last name, please?

A. Yeah. Bastien, B-A-S-T-I-E-N.

Q. And is she in Ottawa? Is that where she's located?

A. I believe ... last I know, it was Montreal. But I don't know ... I don't know for sure. I can't say for sure.

Q. And I interrupted you. I'm sorry. So did you have more to say about that reach-out?

A. Yeah. There was also, later on, I would say months after the tragedy, a conversation with Dr. Alexandra Heber, chief psychiatrist at Veterans Affairs.

Q. When Ms. Bastien reached out to you, did you feel that whatever comments you made to her were well received?

A. Absolutely.

Q. And did you discuss ...

A. Umm ...

Q. Sorry. Go ahead.

A. No. You can keep going. It's okay.

Q. Okay. Thanks. Did you discuss with Ms. ... and how, by the way, how did the reach-out ... what form did that take? Was it a telephone call, was it a meeting, personal meeting?

A. There was a face-to-face meeting. She traveled to our local area office in Fredericton, met with our team. And during

that meeting had said that if anybody had specific questions or ... so I naturally raised my hand and said that I certainly have questions, but I'm not sure that it's a discussion to be had in front of the entire group, to which she answers not to worry, that she had planned to sit down and have a meeting with me one-on-one. So that happened. Again, we're within a week of the tragedy occurring.

Q. And in that meeting with Ms. Bastien, would you have identified the bureaucratic barriers referred to in sentence number one that you went through with me a few minutes ago?

A. I don't believe so.

Q. Any reason why you didn't?

A. Because I used the opportunity to ask questions about what to expect in the weeks and months to come because I was wanting to continue doing my job and wanted to know more about what the department may be expecting of me as a case manager who had been connected to this veteran.

Q. We've had lots of discussion up to this point, Ms. Doucette, about barriers four years on. Can you identify any barriers that you may have seen from the client side ... Mr. Desmond's side? And I'm not in any way suggesting he did anything wrong. I'm just saying, Were there barriers that came

with that client that we might have identified then or now? And may I just ask this ...

A. Umm ...

Q. May I just preface it with this? I know you said earlier in your evidence today, you started out with our friend to say that, you know, this general distrust concept with VAC and dealing with ... not to suggest Mr. Desmond was screaming at you, but dealing with difficult clients on that kind of thing. So I'm just wondering, when I say "barriers", they could be those types of barriers. There may be other ones that I don't know about, so I just wanted to set the landscape for you.

A. Okay. I just want to clarify, as I said earlier, that engagement with Mr. Desmond, there weren't significant barriers in engagement. He, from the get-go, from my perspective as a case manager, was willing to engage in conversation with me, was receptive to my involvement. I would say ... I don't know if you can call that a barrier. I would say there were, in hindsight, multiple times during the case management process where things or options were presented to Mr. Desmond as options for support that he declined or decided not to go with. Is that a barrier? Is that a personal choice? I'm not there to judge or to determine that on sort of his behalf.

But I can say that there were times when ... and this is ... okay. I'm just being careful with the words that I use because I ... there were different times during the case management process where it appeared as though some people supporting Mr. Desmond may have been working harder in some aspects than he was with regards to his rehabilitation.

And I say this without any sort of ... no condescending matter. It happens in a lot of client/professional relationships. And I'm not saying this was consistent throughout the file either but there were times when things were being done for him or presented to him that were probably in his best interest and that he didn't ... he chose not to go with. And that, again, is the nature of the work that we do. We can't force or do more work than what the veteran will allow.

(19:20)

Q. Just to turn direction a little bit, was there any policy within VAC in relation to case managers when dealing with clients who were veterans in terms of straight-up asking them about the possibility of intimate partner violence in their intimate partner relationships?

A. I'm not aware of a specific policy. No.

Q. Was there anything on any checklist anywhere that

would, you know, routinely be asked by case managers to say to someone going back to that opening paragraph that we started with this evening about the anger issues with Mr. Desmond to say to the client, Do you have intimate partner issues? Is there violence with you and your intimate partner? Is there anywhere that anyone in VAC case-management-wise would have straight-up asked that question to a client?

A. There's nothing, I guess, preventing a person ... or from asking the question, but I can't think of a checklist or some kind of prompting mechanism specific to intimate partner violence. We did have, in the area counsellor assessment, questions around family and relationships but not ... and, again, I'm not a policy expert at VAC. But, in my experience, there wasn't something very directive with regards to intimate partner (inaudible - audio).

Q. Would you have asked Mr. Desmond that? Do you remember?

A. About a history of violence? I don't believe so. I do have on record a time where I asked about his risk to others ...

Q. Yes.

A. ... if he was presenting a risk to others, which he

denied.

Q. Switching gears a little bit again. At the time you were there and by the time, I mean, you know, December 2015 and then all of 2016 into the early days of 2017, what was your chain of command? Who would supervise you within VAC and/or the other case managers? Could you take me up a little bit? I mean I realize there's a minister and there's a deputy and maybe a lot of associates and assistant deputies. But on the ground, who would be supervising you?

A. Okay. Veteran service team manager would be ... I would be a direct report to a veteran service team manager, VSTM, who then reports to an area director. I think you've heard from Mr. Marshall who, for a part of his career, was an area director. And the area director, if I'm getting it clear, would then report to the national director of field operations, who at the time was Mme Charlotte Bastien.

Q. Your Honour, I want to ask Ms. Doucette a few questions about the document that we were given yesterday and I don't know if there's an exhibit number for it yet. That's the file review one in your decision yesterday that you disseminated to us.

THE CLERK: Your Honour, it hasn't been marked as an

exhibit, but manually it would be Exhibit P-000303. We can enter it later.

THE COURT: All right. And the BegDoc number of that is?

THE CLERK: It would be CAN052267.

THE COURT: 267? So it's 303. And we'll have it marked ... it will be marked as an exhibit. You can refer to it as Exhibit, as outlined, P-000303.

EXHIBIT P-000303 - FILE REVIEW - JANUARY 10, 2017 (CAN052267)

THE CLERK: That's right and it can be brought up. She can ... (inaudible - talkover).

MR. MACDONALD: If you could bring it up, please. Yes.

THE COURT: Thank you.

MR. MACDONALD: Thank you.

So, Ms. Doucette, it'll get a little larger but it's a file review. Have you seen this before?

A. One time in the context of just reviewing documentation in the context of this Inquiry.

Q. Do you know who prepared it, who wrote it?

A. Not specifically, no.

Q. Can you offer an educated guess who may have written it, given your experience at VAC?

A. Not an individual, per se. I know that our STEOs, our standard evaluation training officers, tend to do a lot of file reviews in different capacities. I don't know, however, in the context of this case if ... I really have no idea.

Q. Okay. Would you ...

A. Umm ...

Q. Sorry.

A. Unless there's a name.

Q. Yeah. Sure.

A. Unless there is a name.

Q. I didn't see one unless it's in invisible ink. I don't know. I didn't see it. Can you give any idea as to what year this would have been written in?

A. Sorry?

Q. Do you know what year ...

A. I did not ...

Q. Do you know what year this would have been written?

A. I don't ... well, no, I'm not a hundred percent sure. It's definitely between 2017 and now.

Q. Yes. Today. Yesterday. Yes.

A. But ...

Q. I understand. That's fine. Thank you.

I'll give you a potential out to maybe speed things up, depending upon your answer. And so when I look at this document, it's not long, there are a number of issues identified in here, that's my characterization, by the writer or writers. And there are comments, very many of them that might what I would say fall under the category of issues that have been identified; need, maybe recommendations. I don't know. Can you speak to any of those as to whether they've been implemented or not, changes made since 2017 when this incident occurred?

A. Well, you would have to take me to the specific recommendation and then ...

Q. Yes. There's a number of them and I'm just wondering if you don't know the answer, maybe somebody else in VAC does. And I won't take up the Court's time, your time, and my time with going through them if you can't speak to them. But you're read it before. Right?

A. If you ... I've read it. It's not super fresh in my memory.

Q. Okay.

A. If you're looking for a definite answer on all recommendations then perhaps Mr. Marshall or ...

Q. Okay.

A. ... someone else in VAC would be a better ...

Q. Sure. So based on that, if you would bear with me a moment, and I'm just going to quickly skim my notes and see if we'll continue or maybe not.

So, Ms. Doucette, if I could take you to the last two pages, pages five and six.

A. Sure.

Q. And page five is entitled, "Opportunities for Improvement".

A. Okay.

Q. And there are a number of opportunities for improvements outlined there, as I would say. I didn't count them. There's a number of them. And, as an example, under the heading "Interdisciplinary Team" IDT, the second bullet, "National IDT guidelines will be finalized, disseminated, and training will be provided by end of fiscal year 2016/'17." Do you know whether that was implemented? I know you're not at VAC anymore, but by the end of the year, fiscal, 2016/'17, you were still there then.

A. Yes. However, national IDT guidelines do not bring anything ... like I'm not clear on what those are, so ...

Q. Okay.

A. ... I wouldn't be in a good position to provide an answer.

Q. Okay. What about with respect to case management services? And I'm just going to summarize this for you. As I read it, what it says is there's a hiring, at least at the time when this was written, hiring and retention process is now underway which should improve the turnaround times noted in the file. Do you know whether there was a hiring and retention process triggered by VAC and how successful it was or was not?

A. I know just about as much as you would based on Mr. Marshall's testimony.

(19:30)

Q. Okay.

A. So it ... yes, based on what he said, there would have been more hires in ...

Q. You reviewed his testimony, did you, or did you watch it live? Mr. Marshall's.

A. I watched some of it, not live, just after the fact.

Q. Okay. Additional resources, consideration of additional supports, and it gives some examples, do you know whether those were put in place?

A. Sorry. I ... were you at the following ...

Q. I'm under "Additional Resources"."

A. Okay. "Consideration of additional supports. OSISS group counselling, Soldier On, to assist veteran on feeling less isolated." OSISS already existed, so I'm not sure ... I'm not really sure what that means, sorry, in terms of additional resources.

Q. No, no. No, that's fine. I appreciate your attempt to answer. "File Transfer", now this is a big paragraph, but I'm going to try and make it small and say it looks to me like what it's saying is it would be very helpful to have a more timely transfer of veterans' files. Do you know whether that was implemented?

A. No. I don't know.

Q. "Health Related Travel". "Promote greater consultation surrounding the HRT decision-making process." I won't read the "for example" part. Do you know whether that was implemented?

A. I ... no. I'm sorry. I don't know.

Q. That's fine. BHSOL, what does that mean? What's that acronym?

A. It's benefits health services online or something like that. That is in reference to the CCM discussion we were having

so ...

Q. Yes.

A. The system that they need to be trained in.

Q. Okay. "OSI Clinic File Closures". "OSI clinics should conduct file hand-overs. Files should not be closed prior to hand-over. A written procedure should be written."

Do you know whether that's been implemented?

A. No, I do not.

Q. Page six. "RRIT/CNCI", what does that mean?

A. The RRIT is the Regina Risk Indicator Tool that Ms. Grant and I spoke about earlier. The CNCI, I remember seeing the acronym. Unfortunately, I can't remember exactly what it means. I understand that the RRIT ... from Mr. Marshall, that the RRIT has been replaced or like it's no longer the same tool that they use.

Q. That ...

A. Ahh ...

Q. Sorry. Go ahead.

A. Yeah. So that's about that.

Q. That first sentence says: "Reinforce existing national guidelines ..." It goes on. Do you know whether those national guidelines were ever reinforced?

A. No.

Q. "Suicidality File Review Process to be finalized and implemented by end of September 2017." Do you know whether that was done?

A. No, not with any certainty.

Q. "Review of Suicide Prevention Business Processes". "Identify gaps in service and update or enhance existing processes by end of September 2017." Do you know whether that was done?

A. I don't know. I think I would not be privy to this information unless it was disseminated to all staff at the specific times.

Q. Yes. Okay.

A. And I'm not saying it wasn't, but I don't have a clear recollection and ...

Q. Now the next one is ... I'm calling them recommendations, but two bullets that deal with followup. Do you know whether those were implemented?

A. I don't ... one thing I know that has changed since 2017 is that there was a new position created and they're called the case management consultant something, who are essentially more people with a background in case management who are

available to provide guidance and support to case managers. I don't know if they do regular file reviews,\ though.

Q. Okay. "CSDN Documentation". What does "CSDN" mean?

A. It's our client service delivery network, so it's our electronic system that we document in.

Q. So the bullet refers to reinforcement. Do you know whether that was reinforced?

A. Well, I'm sure that that gets reinforced regularly by management.

Q. So I appreciate you trying to answer, I truly do. If I was the prime minister and I wanted to say who in VAC would give me these answers that I've just asked you, would Ms. Bastien be a starting point for me, not counting the minister and deputy?

A. I believe Ms. Bastien is in Indiana now. I get the impression that Mr. Marshall probably could have answered some of these questions but I'm not a hundred percent sure.

Q. Do you know whether Ms. Bastien might have been able to answer ...

A. I don't know. I suppose that someone on her team, but I don't know exactly what her day-to-day is like and what she's focused in in terms of portfolio right now.

Q. When is the last time you would have spoken to Mr. Marshall about this process, this Inquiry?

A. I've never spoken to Mr. Marshall.

Q. Okay. Those are my questions. I appreciate your patience. Thank you very much.

A. You're welcome.

THE COURT: Thank you, Mr. Macdonald.

MR. MACDONALD: Thank you, Your Honour.

MS. GRANT: Your Honour, if it helps, I just Googled "CNCI" just for the purposes of the record. It stands for case needs and complexity indicator, just for the ...

THE COURT: Say that again, please?

MS. GRANT: Sorry. The CNCI, where Mr. Macdonald had asked and Ms. Doucette didn't know the abbreviation, case needs and complexity indicator.

THE COURT: Case needs and complexity indicator.

MR. MACDONALD: Appreciate it, Your Honour. I was hoping we would hear Ms. Bastien would be here in the morning or the Deputy but we'll take that. Thank you.

MS. GRANT: All right.

THE COURT: All right. So I think that perhaps this is as far as we're going to go at this time, although I just have

one kind of question area that I want to deal with just briefly.

EXAMINATION BY THE COURT

(19:38)

THE COURT: Ms. Doucette, you, in answering a question you were pausing and you were trying to find the right words to express yourself and it was in relation to ... I'm going to suggest it was an opinion or belief or a feeling with regard to how you and the service providers that you had put in place were working in relation to Cpl. Desmond and how Cpl. Desmond was reacting. And if I was to paraphrase what you said, I would put it this way, that you were working harder than he was working. Would that be a fair way to paraphrase it? I know it sounds a bit harsh but we can add whatever subtleties we want to it, but it seems to me that that's kind of what you were saying.

A. It's potentially fair to paraphrase that way but in the context of what I said was that at certain moments. I did not suggest that he never ...

Q. Overall.

A. ... pulled his weight or ...

Q. No. Okay. All right. But this is what I'd like to ask is it's kind of a long way to get to a question. When Cpl.

Desmond left Ste. Anne's, I know that there was a case conference and you were a part of that case conference. I believe it was August 9th, 2016, and at that time there was a discussion about need for a neuropsychological evaluation. Correct?

A. Yes. That it would be coming through final recommendations.

(19:40)

Q. That it would be coming with the final recommendations. All right. And I understand that the ... we have the document as Exhibit 000116. That document is dated October the 4th, 2016. And I understand that it would have been received by you on or around October 10th, 2016, at least according to various notes, so if you'd just accept those dates for now. So it would have been in your possession and presumably you read it. Am I correct?

A. In October, yes.

Q. When you received it, you would have read it. You would have been familiar with the contents of it. Am I correct?

A. Yes.

Q. Okay. At page three, under the "Observations and Recommendations" by the psychology section, that was Dr.

Isabelle Gagnon under "Recommendations" at the bottom of the page, it says: "First, due to observed and reflected difficulties in the area of behaviour, inhibition, and memory, as well as reported incidents in which head injuries might have been present, we recommend a detailed neuropsychological evaluation."

You were aware of that? Correct?

A. Yes.

Q. On the following page under "Observations and Recommendations", in relation to occupational therapy, the recommendations were:

> A neuropsychological evaluation is recommended in order to determine Mr. Desmond's cognitive capacities. A functional assessment by an occupational therapist is also strongly recommended in order to determine the client's actual functional capacities or limitations. Having a clear portrait of the actual impact of cognitive deficits on the client's functioning, if any, will serve to orient treatment in that it will support the

process of setting realistic therapy goals which are to help Mr. Desmond attain a satisfying level of participation in his activities and develop a sense of having an improved quality of life.

You would have been aware of that. Correct?

A. Uh-huh.

Q. Yes. So it seems that there was not only the neuropsychological assessment or evaluation, but also a functional assessment by an occupational therapist to actually kind of flesh out the limits, if any, of whatever cognitive capacities he has or whatever deficits might exist. Would I be correct in putting it together that way?

A. Yeah.

Q. Yes?

A. Yes.

Q. All right. When ... if we could have a look at P-000117, please, page 7 of 17. It's the progress note, it's 2016-11-07, and it reads in part:

Phone communication with psychologist Catherine Chambers of Antigonish, Nova Scotia. Provider recommended by NS

colleague. She confirms she has availability for new clients at this time. Works with many veterans and specializes in trauma/PTSD work. Without providing any information through which veteran could be identified, CM and psychologist came to following agreement. Veteran will be asked to be in touch with her to set up a first informal appointment. Once that is confirmed, CM will send consent forms to her office for veteran to sign. Psychologist can keep a copy for herself, if needed, and returned. Once they are returned, case manager can provide psychologist with some information that is relevant to veteran's psychological health. No new psych assessment needed at this time.

You recall writing that?

A. Yes. I see it.

Q. Okay. So that was written after you had received the report from Ste. Anne's and after you had read the report from Ste. Anne's and after the report in Ste. Anne's had recommended

not only the neuropsychological assessment or evaluation, but also occupational health had recommended a functional assessment to determine actual cognitive capacities. Am I correct?

A. I apologize. I missed that last part.

Q. The report ... you write in your progress notes that no new psych assessment needed at this time. You write that November 07 and this is as you're having discussions with Ms. Chambers. Yet you were aware that in the report from Ste. Anne's that they had, in fact, recommended two reports ... two assessments be done; one, a neuropsychological evaluation, and; secondly, that there be a further functional assessment by an occupational therapist to determine cognitive capabilities. Am I correct? That is, that they also recommend a neuropsychological evaluation to determine cognitive capacities.

A. Okay. Yes, I see.

Q. So ... but you write, in your report, that no new psych assessments were needed at that time, yet there were at least recommendations for two serious assessments, in my view, be done on Cpl. Desmond to determine cognitive functioning.

A. Okay. So ...

Q. Has it ... does it ...

A. ... I understand.

MARIE-PAULE DOUCETTE, Examination by the Court

Q. Does it not occur that when people are having difficulty kind of getting through to Cpl. Desmond, it may be as a result of his cognitive deficits as opposed to simply attitude and that it requires some special work to deal with him because of these cognitive deficits that were never fleshed out? Because it seems to me that those assessments were never done and actually were never even scheduled to be done.

A. If I could start with just speaking to the comment "no new psych assessment needed at this time", I understand how that could seem contradictory. When I wrote this, I was writing this in the context of the work with Ms. Chambers. So I left it up to her to determine if she wanted to do a thorough assessment of her own ...

Q. So let me ask you this then. How ...

A. ... having (not?) mentioned that we ...

Q. How do you expect her to know what had happened in Quebec to know that there were already suspicions of cognitive deficits? Now she's going to be speaking to Cpl. Desmond in that context without knowing that deficits have already been recognized.

A. Well ... okay. So when she is in contact with Mr. Desmond, so this is pre her having contact with Mr. Desmond, she

is going to be asking the questions, as a professional, that she feels she needs to pose to him. I make it clear that there's information that can be provided with his consent. And I am confident ... I can't say that it was the time of this conversation, but that in a conversation with Ms. Chambers, I did mention to her at some point that we would be looking into neuropsychological evaluation, because I was interested to know if she knew of a resource that provided this kind of specialized resource.

Q. And that ...

A. So I understand that it can ...

Q. Sorry. How would you have that conversation with her when she never signed the consents to allow you to release that information?

A. As I said, I can't say for sure that it was in the context of this conversation. I think it may have happened in a follow-up conversation.

Q. You mean after Cpl. Desmond's death?

A. No. No.

Q. Well, how would it ...

A. Before.

Q. How would it have happened between ... you mean it

happened between November the 7th and January 3rd?

A. All I can tell you is that I remember specifically asking the providers that we were enlisting if they knew of any colleagues in their area who were trained to provide neuropsychological assessment.

Q. So would that mean that you made both Ms. Chambers and Ms. Boone aware that Cpl. Desmond may have been experiencing some cognitive deficits and required a neuropsychological evaluation to determine if they existed or the extent of them? You would have specifically told that to both Ms. Chambers and Ms. Boone so they would know how to approach Cpl. Desmond when they dealt with him?

A. Well, likely not in those exact words but that there was a recommendation coming from treatment. Yes. And ...

Q. This very clear recollection you have of having had a conversation at some point in time in whatever terms you might recall, that clear recollection never made it into any of these notes either at the time you wrote them or when you provided your summary at the request of the deputy minister. Would I be correct?

A. Correct.

Q. Okay. Well, thank you. That was the only question I

wanted to ask at this time.

THE COURT: We will adjourn until 9:30 tomorrow morning, please. And as I said earlier today, because we want to complete this for Ms. Doucette so that ... we appreciate that it's been something that's of concern for everyone for some period of time. So we'll get it concluded tomorrow, Ms. Doucette, however long it might take.

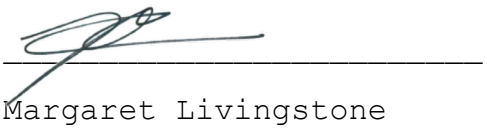
All right. Thank you very much then. We're adjourned for the night. Thank you.

WITNESS STANDS DOWN

COURT CLOSED (19:52 HRS)

CERTIFICATE OF COURT TRANSCRIBER

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



Margaret Livingstone

(Registration No. 2006-16)

Verbatim Inc.

DARTMOUTH, NOVA SCOTIA

July 4, 2021