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: March 2, 2021

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DR. ROBERT OUELLETTE

EXHIBIT LIST

March 2, 2021

COURT OPENED (09:35 HRS.)

THE COURT: Thank you. Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Good morning, Dr. Ouellette.

DR. OUELLETTE: Good morning.

THE COURT: Perhaps before we begin we could have Dr. Ouellette sworn, please.

DR. ROBERT OUELLETTE, sworn, testified:

THE COURT: Thank you for your making yourself available to us today, Dr. Ouellette. I think that we're going to begin this morning with Mr. Russell is going to have some questions for you. If you have difficulty either seeing us or hearing us you just have to let us know and we may be able to explore the issues at least in some limited capacity. All right.

A. Yes.

THE COURT: Thank you. Mr. Russell?

DIRECTION EXAMINATION

MR. RUSSELL: Good morning, Doctor.

A. Good morning.

Q. We meet again.

A. Yes.

Q. Ideally we would have been meeting in person; however, it's a different year for sure.

A. Yes.

Q. So, Doctor, if at any point I cut out, as the Judge indicated, just signal, let us know, we can stop things. As

well, I understand that you are bilingual, however, English may not be your first language.

A. No, it's not my first language but I can understand very well. Sometimes I have to find some words and I have my papers with me now for that.

Q. Sure, so if at any point, Doctor, you need to take a moment or if you need me to rephrase a question, just let me know.

A. Okay. Thank you.

Q. So, Doctor, I'd like to start a little bit this morning. If you could state your full name and we're going to review your qualifications.

A. Okay. My name is Robert Ouellette.

Q. And, Doctor, I understand that you've been a psychiatrist for quite some time. How long have you been a psychiatrist?

A. Since 1974.

Q. And, Doctor, we're going to pull up on the screen what is marked as Exhibit ... I guess it would be the most recent exhibit, it just came in last night.

THE CLERK: 256.

MR. RUSSELL: 256.

EXHIBIT P-000256 - *CURRICULUM VITAE* OF DR. ROBERT OUELLETTE

A. Mm-hmm.

Q. Now this is a *CV* of your qualifications that we had transcribed. It won't be my intention to review everything obviously in your *CV*, I'm more interested in I guess if we could start more recently and just sort of work our way back a little bit.

What is your current position?

A. Actually, I work at the Ste. Anne's Hospital for Veterans in Montreal and I've been there since 2010 as a general psychiatrist and also as a psychiatrist in the stabilization and residential programs.

Q. So prior to 2010 when you first became involved with Ste. Anne's, where had you been prior to that time?

A. Okay. In 2009 I was working ... I did work for a year at the Saint-Jean Base, military base, with recruits for a year, replacing another psychiatrist who was taking a year vacation.

And since 2001 until 2009 I worked at the Valcartier Base, CF Base near Quebec City and I was a psychiatrist there for active military members.

(09:40)

Q. So I wonder, if you could tell us from 2001 to 2009

thereabouts, the first base you would have worked at, what was your role and what ... who were the type of clients that you would have seen?

A. Well, then I was a clinical director of the team, we were four psychiatrists there at that time, and my work was assessing and treating active members of the CF coming back from missions mostly. Those missions at that time were missions in Bosnia and Haiti and some members from previous missions, but mostly Bosnia, and then after that there were missions in Afghanistan. So I was the psychiatrist there (on-site?) one of four psychiatrists working there for assessing and treating patients with a team.

Q. And you indicated in 2009 you went to a second base. What base was that, the second one?

A. 2009 I came back to Montreal and then they asked me to replace a psychiatrist at the Saint-Jean Base, which is a base for recruits, young members, coming in the CF, and I did a replacement for a year.

Q. So, Doctor, is it fair to say that from, I guess, about a 20-year period your client base has solely been members of the military or former members of the military?

A. Yes, that's true.

Q. And so, Doctor, if you could tell us a little bit about your sort of post-secondary training in that 20-year period as it relates to diagnosing, treating members of the military or former members of the military.

A. Excuse me, post-military training?

Q. Post-second ... I guess training - any training you would have received outside of your general experience ...

A. Oh yes.

Q. ... in the last 20 years.

A. Well, it was part of our work and our work there to have some training from specialists in post-traumatic stress disorder every year then. And, for example, I remember there were two weeks' training with (Pascal Briand?) the specialist in PTSD there, and there were all kinds of training there.

Q. And, Doctor, so did you have any experience dealing with former members or current members of the military, Canadian Armed Forces, prior to 2001?

A. Yes. Well, I was doing expertises as a general psychiatrist since 1978. I was doing expertises in the work field with organisms in Montreal, and then I began interesting to PTSD because at work people experience traumas and ... For example, I was working for CSSD in Montreal, which is an

organism for work accidents and I could see a lot of persons experimenting PTSD because of traumas at work and I was interested in that.

At my office, I was treating them, some of them, not the expertise but the others, some other patients. And then some veterans began to come at my office to seek assessments and treatment, so I developed quite an interest in that.

And then in 2001, I decided to accept a post at Valcartier where they needed civil psychiatrists because they were ... they had a lot of assessments to do. And I decided to go there and to be full time as a psychiatrist to do those assessments and treatments. There were a lot of persons coming back from missions, especially in Bosnia then at that time.

Q. And so, Doctor, if we roll it back to 2001 that's 20 years, and then you talked a little bit about prior to your acceptance of the position on base in 2001, are you able to estimate how many years, I guess, you would have had experience in diagnosing and treating members or former members of the Canadian Armed Forces as it relates to PTSD and other mental health disorders?

A. 20 years.

Q. Okay.

A. I've been working only with patients from the Canadian Forces since 20 years.

Q. So, Doctor, I'm going to ask you a few general questions and then we'll get into specifics.

So when you're treating veterans or active members of the Canadian Armed Forces, we hear a phrase "operational stress injuries". What is an operational stress injury?

A. Well, it's an injury that occurred during the missions or during the presence of military men and women at work but more specifically when they are in missions.

Q. And, Doctor, is it fair to say that in your career in treating members of the military or past members of the military, that their clinical, I guess their psychological portrait, if they have various diagnosis and struggles with mental health, are they always all attributable to operational stress injuries or can it be some operational stress injuries and other things that were unrelated to their actual service in the military?

A. Well, when I was in Valcartier, it would have been all kinds of mental illnesses, you know. It could have been depression or anxiety or bipolarity and also PTSD. It was a wide range of pathologies.

When I was in Saint-Jean, then it was young recruits who didn't go to missions but they had some mental illness issues then, so we would be treating them for that, and also their teachers. But since I have been at the Sainte-Anne-de-Bellevue Hospital it is mostly PTSD that we see at the outpatient clinic. I work in the outpatient clinic there, and I also work in the stabilization program.

Q. And we're going to get into the ...

A. So mostly ...

Q. Go ahead, sorry.

A. Mostly those persons are suffering from PTSD, but they can also suffer from depression, mostly because of their work. It has to be work-related.

Q. And, Doctor, we're going to get into the structure of the program momentarily. I'm just trying to get a sense of in an average year at Ste. Anne's, how many members ... and I'll start using the term "members of the military" that'll include non-active members of military ...

A. Yes.

(09:50)

Q. ... or those involved with Veterans Affairs.

So how many members of the military would you see in the

course of a year on average?

A. Okay, at the outpatient clinic I have 110 patients to see. This is my caseload. So I have to see them once every three months, something. And the new patients I have, I have to see them once a month. This is in the outpatient clinic, I have 110 of them. We are seven psychiatrists there and we each has his caseload.

In the stabilization program, usually we have one patient every week to assess or every two weeks. It depends if the patients stay with us for a long time or short time. But usually during a year I would see ... well, I don't have the statistic but I would say something like 25 to 35 patients maybe.

Q. And so, Doctor, I know you may be reluctant to sort of answer this question, but would you say that being a psychiatrist that exclusively deals with members of the military would be sort of a sub-specialty of psychiatry?

A. Well, it is difficult to answer to this because the pathologies of those persons are pathologies we see in general psychiatry. But the setting ... you know, the fact that they work in the military; the fact that they have special conditions; the fact of their work is different than the general

population and it's kind of a sub-speciality but not necessarily.

We have to know a lot of things about the military. We have to know what is ... what work they do, the ranks, the missions, which is very extraordinary kind of work. But we can find that also in the RCMP, for example, or in certain police corps.

Q. And so, Doctor, what ...

A. But you have to be aware of the kind of work they are doing. Yes.

Q. So, Doctor, in the next series of questions I'm going to try to draw out some of the differences and uniqueness of military-based clients suffering from mental health disorders and those of the general population.

So how does a military client may they present in their symptoms that may be different from a client in the general population with the same diagnosis or mental health disorders? What is the difference?

A. Well, when I was in Valcartier, for example, the military would come to us after waiting a long time, you know. They were waiting a long time to consult because they knew that the fact of consulting could threaten their work; the fact that

they would have continuity in their work in the future.

So the pathologies that we saw there were already chronic pathologies. People trying to treat themselves in another way, other means than seeing a psychiatrist. Sometimes they would take alcohol or drugs or ... to try to treat themselves. They would wait a long time to consult.

Q. So is it fair to say that ... and I know that it's a generality, it's not specific to every single client, but what you may have experienced and noticed is that military-based clients maybe tend to be delayed in seeking treatment for mental health?

A. Yes, this is right. Yes.

Q. And with that as well, did you notice any difference between military-based clients and the civilian population in terms of opening up and disclosing the details of their trauma and their understanding of it? Were they a little more reluctant, I guess, than members of the general population?

A. Yes, indeed. Because of the consequences on their work, on their future work as military men and women. So they would wait a long time to consult and then they would be ashamed to consult at the beginning.

Q. And what do you mean by ...

A. Sometimes it ...

Q. What do you mean by the consequences and what do you mean by may be ashamed?

A. Well, in face of the group having a mental illness in the military is considered as being feeble, being ... not being fit for work, you know. They judge themselves a lot. So they wait a long time and they don't want people to see them consult.

For example, the stairs coming up to the mental illness ward at Valcartier, they would climb these stairs saying it was the "stairs of shame". So there were a lot of judgments there and ...

Q. And who referred to it as the "stairs of shame"?

A. Well, they were saying that in general, saying that they didn't want to climb those stairs to come to seek mental treatments.

Q. And so was what ...

A. But in the ... yes.

Q. Would you say as a general ...

A. In the long ...

Q. Go ahead. Sorry.

A. In the long run, this mentality changed because there were a lot of publicity and psychoeducation on that, but when I

was there at first, it was like that.

Q. And when you say it changed, roughly around what time did you start to see a change and sort of more an open acceptance?

A. Progressively until now there is a change because there's a lot of publicity done in the Canadian Forces' publications. The general population knows about PTSD now, about the treatments so the mentality changed. During 20 years I've see a lot of change in that.

Q. And, Doctor, but to this day do you still see an undercurrent quite frequently of a reluctance to seek help and a guardedness to really open and confide - a veteran to confide in a mental health professional?

A. Yes, I can see that still because it has consequences on the work of the military. If he is judged not fit to go to missions, to work as a military, then he would be released from the military. And this is ... this give them a lot of anxiety because they don't know what they are going to be doing outside the military.

(10:00)

Q. And how frequent do you see that in military members that you treat that it's a pressing concern and anxiety, this

concept of they may be deemed unfit or they may be ... their duties may be altered or ultimately they may be discharged? One, how frequent do you see that; and two, what impact does it have in the global portrait, I guess, of mental illness?

A. Mm-hmm. Well, I think that everybody thinks about that. They have to be aware that if they come to be treated in mental health by mental health professionals, it can be that they won't be able to work anymore after that, so they are going to be released. They have to evaluate that. Some of them go back to work, but most of the patients with PTSD, they have permanent disabilities, so a lot of them are going to be released and they have to be helped, and they are, to find work. There are all kinds of programs to help them finish their studies and study new types of jobs, work, and they know that.

Q. I'm going to ask you a little bit about this concept of therapeutic alliance and the importance of it.

A. Mm-hmm.

Q. From a psychiatry perspective, I guess, first, what is therapeutic alliance from your perspective?

A. Well, okay. The alliance is that the patient comes with a special mental illness and the alliance is the fact that the psychiatrist or the psychologist or any member of our team

are going to help them to improve, to get better. So it's kind of a contract between the patient and the professional to make a treatment plan to help. The desire to help the person to be well, to be better.

Q. And how important is a therapeutic alliance before you can even get to understanding their mental health disorders as well as coming up with a treatment plan? Is therapeutic alliance sort of step one and everything depends upon it?

A. Well, we take some time to establish a good therapeutic alliance because it is essential if we want to treat a patient. For example, if a patient comes to see me and I say to the patient that we have to take some medication for sleep or for anxiety or for depression, then we count on the patient's desire to take those medications to be well. He has to have respect and trust in the professional to try something to help him. It doesn't mean that ... yeah.

Q. In an ideal ...

A. Okay.

Q. In an ideal scenario, you would be presented with a client on a first occasion and the therapeutic alliance crystallizes and it's perfect. However, I'm wondering if you could explain to us any unique sort of challenges or barriers

that goes into building a therapeutic alliance with a member of the military.

A. Yes. Well, sometimes some patients are reluctant to enter rapidly in a therapeutic alliance, you know? And we have to work on that. We have to make some psychoeducation. We have to educate the patient about the illness that he has, the treatment that we can do to help him. We have to have him see, for example, a doctor to see if everything is okay with his health, physical health. We have to gain this respect and this trust from the patient and sometimes it takes a few weeks or a few meetings with the patient and then things can improve a lot. But it is not done at the first time, at the first minute of the meeting with a patient.

Q. And in your experience in terms of general, I mean it varies from client to client, but is there some added level of difficulty or struggle with building a therapeutic alliance with a member of the military as opposed to the general population?

A. I think it depends on the pathology, on the mental illness that a patient has. It depends on his personality and also it depends on what the treatment is going to have as consequences on their work.

Q. And we're going to get into the specifics of Lionel

Desmond, but would you say that Lionel Desmond was the type of patient or client that it would have taken a little bit of time to build a therapeutic alliance with him?

A. Yes, I can say that.

Q. And, Doctor, I'm going to ask you a little bit about the uniqueness of ... the concept of continuity of care. So basically the handoff in treatment. This idea that a member of the military could go from a OSI clinic in a province, to Ste. Anne's, to the community.

A. Mm-hmm.

Q. What is unique and what are some things that you have to be aware of when you're doing that sort of handoff in the continuity of care as it relates to military veterans?

A. Could you repeat the question because ...

Q. Sure.

A. ... I have to ... yeah.

Q. Sure. The concept of continuity of care ...

A. Continuity.

Q. ... moving a patient ...

A. Okay.

Q. ... from one group of professionals to another group of professionals.

A. Okay.

Q. So what sort of things can you identify that are important when a client moves from Ste. Anne's to the community?

A. Yeah, okay. Well, as for continuity of care, I think that the most important thing right now that I can see is the fact that our cares are done in the multidisciplinary setting, okay? So there are a lot of professionals around the patient and he has meetings with everybody. Psychiatrists, psychologists, social worker. And then if one of them is not there, the other persons are going to be there for him. The nurses, for example. If the patient has to go elsewhere, the important part for continuity of care is to give all the information to the new team he is going to see. And then coming to Ste. Anne, we have to have all the details, all the details of the files, you know? All the ... we have to know that. And if he is sent elsewhere, we have to be very ... well, I know what to say in French but ...

(10:10)

Q. Well, I guess I can ...

A. ... it's not so easy in English. Yes.

Q. I can sort of ... I'll try to draw it out a little bit more, I guess. So what I'm taking from what you're saying are

two things. One, the sharing of information about the background ...

A. Sharing of that, yes.

Q. Is that important?

A. Yes. That's what I had in mind, the sharing of information between the team, the different teams, from the active member to veteran's member to special member that are going to see the patient. For example, the Ste. Anne stabilization program or residential program. All this information circulating from one to another is essential. Everybody has to have all the information.

Q. And the second aspect that I took from what you said originally was, we've heard some provincial Health Authority members refer to it as a circle of care. So what you described when you said "multidisciplinary" is mental health professionals that specialize in different areas. Is that what you're referring to, that it's important to have more than one resource for a military-based client in the community?

A. Yes. We work as a team. We work in a multidisciplinary manner everywhere and it's the ... I've seen that in Valcartier and Saint-Jean and Sainte-Anne-de-Bellevue. It's the way of working right now. Nobody works by ... alone in

his office right now.

Q. And what ...

A. Everybody shares the information.

Q. And what sort of members of this team, what background would they have? If you can give us an example of maybe three people that would be of this circle of care team.

A. Well, there are nurses, for example, in the outpatient clinic. The nurse sees the patient first. She does a nursing assessment, she sees if the patient needs urgent care and to give ... there is an admission committee and then the patient is directed where she or he suggests.

So after that, the patient can go to a psychiatrist, for example, to be assessed and to receive some medication, and at the same time, the psychiatrist will recommend, for example, psychotherapy with a psychologist. We have psychologists in Ste. Anne. If there are no psychologists available because there's a lot of persons coming in, we can send the patient to a psychologist in the civil surroundings.

But also, if we see that the patient has a drinking problem or a drug problem, we have personnel specialized in toxicology. So they are going to treat a patient. We also have an (omni?) practitioner who can see the patient if he doesn't have a doctor

at home. He can be sent elsewhere. And if there is a problem at home, we have social workers and the social worker can do some work with the family or the spouse or work. So ...

Q. And what is the role ... I understand that Ste. Anne's offers occupational therapists as well?

A. Yes.

Q. And would they be part of this treatment team?

A. Yes. Ergotherapist, occupational therapist, physiotherapist. We have, at Ste. Anne, we have a pain clinic with a physiotherapist. So the patient, when he's taken under our care, has a wide variety of specialists that can help them. They even have, for example, peer. What we call peer aide ... aiding peer, peer support, one person who is a military man or woman, and who can listen to them, go at home with them and help them. So ...

Q. And so, Doctor, when ... and I know it varies from client to client, but when a client leaves Ste. Anne's and they leave with a series of recommendations, do you expect that similar-type services could be offered in the community when a veteran returns home? You know, they're leaving a setting where they have a social worker, a peer support, a psychiatrist, an occupational therapist. Is that sort of structure, when they

enter the community, important for their continued stabilization?

A. Well, I cannot answer to that because I don't know what is going on anymore outside the ... but they are supposed to have care but I don't think they have so much care outside the Canadian VAC or Forces. But they can have psychiatrist, psychologist, they can have social worker. They can have that, but in the general population, those services are much less accessible for them. So that's why we treat them. We try to improve their mental health and then we refer them to some organisms outside. And if something goes wrong, if their mental illness comes back, so they can ask us to go on with that treatment.

Q. So I'm going to ask you a little bit more about the Ste. Anne's clinic. I understand that a veteran is referred to Ste. Anne's through Veterans Affairs Canada. Is that correct?

A. Correct, yes.

Q. And a referral could come, I guess, from an operational stress injury clinic through Veterans Affairs ultimately to Ste. Anne's? Is that correct?

A. Correct.

Q. And so ...

A. As long as they have a team treating them. They are veterans. They are treated in OSIC for stress, operational stress disorders, but sometimes it's a psychiatrist because some populations are isolated and they have a psychiatrist, they have a team referring us patients, yes.

Q. So, Doctor, the structure of the Ste. Anne's clinic, I understand that there are two aspects of the program. There's the stabilization phase first and then there's a residential phase.

A. Yes.

Q. I wonder if you could tell us a little bit about, first, I guess, the stabilization phase. What is it and why is it first?

A. Mm-hmm. Well, I work ... me and the other two psychiatrists, we work in the stabilization program. Our work is to make a good assessment on their pathology. After that, to choose the right medication according to the assessment, and then to keep them with us to see how it works. If the medication helps them or not, maybe we will have to do some testing with the medication, for example, to have a better sleep, to feel less depressed, less anxious. So we do that in the stabilization program and then when the patient is

stabilized, has less anxiety, less fatigue, better concentration, then he is ready for the residential part where he will undergo group therapies and with other patients and this part is going to last for about eight weeks and ... yeah.

(10:20)

Q. So before we get into the residential phase, so is your primary involvement at Ste. Anne's at the stabilization phase?

A. Yes.

Q. And ...

A. The ... yes.

Q. And what is stabilization in a mental health context?

A. Stabilization is we have a chart before the patient comes to us, okay? And it's on a voluntary basis. The work we do is to work on the symptoms, you know. We make an assessment. We see, for example, that a patient has PTSD. Most of them have PTSD and we have to work on symptoms, we have to ... for example, to work on their sleep because those patients, they didn't sleep for years. And we have to help them sleeping better, to feel better in the morning, to be able to meet our persons on a quieter basis, and also to be less anxious during the day and to be more at ease with others in their personal

interrelationships.

Q. And is the stabiliz- ...

A. So that's the work ... yeah?

Q. And is the stabilization phase always for a set duration or can it vary from patient to patient?

A. Set duration? Excuse me?

Q. Stabilization, is it always for a set period of time, that phase, or can it be longer or shorter?

A. No. We don't know how much time the patient is going to stay with us. Sometimes it's very short. Sometimes the medication is well working with them. We just do an assessment. We just do some little changes in the medication and then he goes right away to the residential program. But most of the time, and sometimes and most of the time, they have been treated a lot of years before by other professionals, psychiatrists and psychologists, and they need a different assessment. They need new medications. And then we have to check if the medication works. Those medications, for example, antidepressants, sometimes they work only after a few weeks. Four to eight weeks sometimes. And we have to know if it works well with them, so they have to stay a longer time with us. And ...

Q. So speaking of medications ...

A. Yeah.

Q. ... do you want to see a client in the stabilization phase that ... in Lionel Desmond's case, he had been consuming cannabis. He had been prescribed cannabis.

A. Yeah.

Q. He had a number of other prescription medications. Is it important for you to be able to observe someone like Lionel Desmond in the stabilization phase without medications and why do you want to see that?

A. Yes. It is a prerequisite for patients received in the stabilization program that they should have stopped drinking and taking cannabis or other substances many weeks before they come to us. At the beginning, it was four weeks. Now we accept two or three weeks. Sometimes we help them because there are the toxico centre near the hospital and sometimes they go there for a month or two. And when they come to us, they don't take alcohol or cannabis or other substances because those substances can interfere with their medication. So we have to have a patient that we can observe and observe their way to react to the medication we give them.

Q. And is it helpful for you to be able to get an accurate diagnosis and a full assessment of symptoms and what

may or may not go into the ultimate treatment when they're free of those substances?

A. Yes. It is essential for them to come to us and not to be intoxicated or on other medications or drugs. And that's the good part of the stabilization, you know. Many professionals in Canada in other bases send their patients to us because they cannot observe the patient during many days, how they react to others. Are they taking really the medication that they are given? What are their relations with others, with other members? Is their sleep really good or bad? So we can make those daily observations in the stabilization program and then after that, and we can have a better view of the patient's behaviour and symptomatology.

Q. And is it fair to say that a psychiatrist in your position who gets to observe a client that frequently and free of any sort of external interference, are you at sort of an advantage compared to maybe other psychiatrists in that you see a maybe truer version of the potential diagnosis?

A. I think it's extraordinary advantage that we have because we can observe the patient daily for days, weeks, months. We can look at their functioning, at their personal relationships. The psychiatrists or psychologists in the OSIC

centres, they see the patient only an hour or two and they don't have direct observations of their behaviour. So it is an extremely important advantage that we have.

For example, when they come to the stabilization program, we ask ourselves, why did they not respond to the treatment at home? And sometimes it happens, but not all the time, but it can happen that we prescribe medication to a patient and he doesn't want to take it.

At home, he can forget to take it. Not saying that to his doctors, but when we see that, we understand why he didn't improve at home. Some of them. But also some of them take the medication in the wrong way, so we have to check on that too. Are they taking it the right way? We have direct observation and this is very good.

(10:30)

Q. So is it fair to say that when a member of the military is referred to Ste. Anne's and then ultimately, recommendations come out of Ste. Anne's, is it fair to say that those recommendations are coming from a very unique perspective and a perspective that is an advantage and that you get a true sense of what is going on with the patient. Is that fair?

A. Yes, this is fair, yes. And this is why they send

them to us. And at the same time, the patients coming to us are all in the military or are all veterans, so they stick together. They have good comprehension of each other and they feel more secure in those settings.

Q. I'm just going to ... before we actually turn to Lionel Desmond, the last series of questions I have are about information you, as the psychiatrist, at the stabilization phase. What information or documents and sources of places do you get information from when you first see a patient in the stabilization?

A. Okay. When ... first I have to see that the patients are seen on a voluntary basis. They are free to go back home if they wish to. They are not confined to the program. And first we receive a demand from the team of the patient at home; for example, New Brunswick, Nova Scotia, Newfoundland, or even sometimes the west of Canada. And we have an admission committee where we reunite every week. In this commission committee, there's a nurse responsible for the admission. We call her the "admission nurse". The psychiatrists, me and Dr. Abdallah Dallal, which is there with me since the beginning, and Dr. Sansfacon, a new psychiatrist that has been with us. There's the general practitioner for the medical part, and a few

other. The coordinator - a clinical coordinator - and a few other persons reuniting every week.

Q. So these ...

A. And then we take ... yes?

Q. So these ... just so I can back up a little bit. So at the initial phase, you've referenced yourself and three other individuals, two other medical doctors, and a clinical coordinator.

A. Mm-hmm.

Q. That's at the very outset. So why is it important to have that many sort of people on the ground immediately to sort of start this whole process?

A. Yes. It is very important because we have ten patients in the ward and we have to make sure that everything is going to be all right with them. So we have criterias for admitting persons and we have contraindications for them. And the admission nurse looks at the file. It's coming, for example, from a team in Nova Scotia, and we look ... they send us the patient's file, the psychiatric evaluation, and information about the patient. For example, is the patient psychotic? We cannot treat psychotic persons on our programs because most of the treatments are group therapy and they will

not be able to do group therapy with those kind of patients.

We cannot receive patients who have medical conditions ... very active medical conditions. For example, diabetes, which is not stable, who has a chronic illness that requires treatment all the time. There are contraindications. For example, we cannot receive a patient who will not be there all the time. Sometimes some patients have obligations at home. Sometimes they have a criminal record that demands them to go to court a lot of times, so they won't be able to attend to all the meetings.

Q. So what I'm interested in, Doctor ...

A. Yeah.

Q. What I'm interested in is when you were given the information from, say, an OSI clinic in Nova Scotia or New Brunswick ...

A. Yes.

Q. ... you referred to psychiatric reports. If there was a psychologist that was treating them at an OSI clinic in Nova Scotia, would you have those OSI reports as well?

A. We cannot those reports, but the nurse is going to call. She is ... I don't know how to say that in English. *Le pivot*.

Q. Intake?

A. Yes. She would be the one, the centre of this committee, and she can call to the reference and ask for the reports.

Q. So do you have, at the Ste. Anne's clinic, so there is a nurse that oversees gathering up all the documents and reports which then find themselves in your hands.

A. Yes.

Q. Do you find that help- ...

A. Yes.

Q. Do you find that helpful?

A. It is essential. Essential.

Q. And why is it essential to have someone in that position that gathers the documents that can be turned over to the treating psychiatrist?

A. Okay. Well, for example, some patients want to come to our programs but they don't want to change their medication, and sometimes they don't even want to take medication. So what can we do for them? They will be very anxious and they can be disturbing for other patients on the ward. So we have to be sure that the patient who will come to us is not drinking, is not taking drugs, is aware of the fact that we're going to try

new medications with him, is accepting the conditions in which he is going to be living with us. And the nurse there and the committee make sure of that.

Q. So why is it helpful that you have this information and previous reports already gathered and brought to your attention? How is that helpful?

A. Well, so it is very important because at our hospital, for example, we cannot take patients who are suicidal or homicidal because we're not equipped for that. If a patient comes because he is suicidal and it takes a different kind of a setting to treat them, they cannot be treated with us.

Q. I think Judge Zimmer may have a question there.

THE COURT: Sorry. All right. So Dr. Ouellette, just so that I'm clear, we're talking ... I know you're talking about the review committee, the admission committee, that decides whether or not a particular individual will be accepted into your program, is that correct?

A. Yes, that's correct.

(10:40)

THE COURT: And it's the nurse that's part of that group that would be responsible for looking at all the material that has been sent to you by way of, or as part of, the reference,

and then if that person, in their experience, decides that there's more information that may be required, they have the ability to collect that and present it to the committee when you look at all of the circumstances, all of the background, to decide whether the particular individual is suitable for your program. Am I correct?

A. Yes, correct.

THE COURT: All right. Once the individual is accepted into the program, that material, that case file, if I can call it that, it would still be available to the various individuals on the team that are dealing with the patient. Am I correct?

A. Yes. Correct.

THE COURT: All right. And I understand it's important to have all of the background information because in your past experience, you know that some people are more suitable, some people will fit in, some people are made more or less suitable for your particular kind of program.

A. Yes.

THE COURT: Am I correct?

A. Yes.

THE COURT: All right.

A. Correct, yes, yes.

THE COURT: All right, thank you. So there is a difference between what you look at at that initial stage to determine admission. Once they're then admitted, you meet with them, you are trying to develop the therapeutic alliance, and it's at that time that you have discussions about a plan or how the treatment plan is going to move forward?

A. Yes, correct.

THE COURT: All right. Thank you.

All right, Mr. Russell.

MR. RUSSELL: Thank you, Your Honour.

So, Doctor, if we could turn to specifically now, Lionel Desmond. We know that Lionel Desmond had become involved with the Ste. Anne's clinic. He had entered the program on May 30th of 2016 and he left August 15th, 2016. So what was your primary role in Lionel Desmond's care while at Ste. Anne's?

A. Okay. My primary role was to assess him, to make a complete assessment with a diagnosis and treatment plan, and that's what I did on the 31st of May when I saw him.

Q. So, Doctor, to your understanding, did ... I guess before we get into that, how frequently would you have met with Lionel Desmond while he was at the Ste. Anne's clinic from May 30th to August 15th?

A. Okay. Well, I saw him only at the stabilization program because I'm not in the residential program. Once the patient goes to the residential program, he is supervised by the doctor, the omnipractitioner there, and by another on other grounds. So I saw him only at the stabilization program. It was from the 31st of May until the 28th of June. I saw him ...

Q. Go ahead, Doctor.

A. Yeah. I saw him five times during his staying with us at the stabilization program.

Q. And we're going to get into the specific diagnosis as we move to your May 31st meeting with him.

A. Mm-hmm.

Q. So I assume Lionel Desmond came to you with a pre-existing diagnosis.

A. Yes.

Q. And were you going to assess and diagnose Lionel Desmond independently of what that diagnosis was? Were you going to sort of see, I guess, for yourself?

A. Well, I had to have my own opinion. I had to see the patient. It's like, yes, it's important to have the assessment done by the others before, but I have to make my own opinion of the patient when I see him. It was a different assessment.

Q. So, Doctor, in general terms, at the early stages, so when you first meet with him May 31st, did Lionel Desmond strike you as someone that was motivated to be involved in the program?

A. Yes. I saw him as wanting to feel better, to be treated for his problems.

Q. And in your time ...

A. He was motivated.

Q. And in your time up to June 28th, did he seem to put in a genuine effort to cooperate with recommendations with the ultimate goal of getting better? Did he seem to put in a genuine effort?

A. Mm-hmm. Well, at first he did say that he wanted to give cooperation to the treatment. He was accepting the treatment. But during the ... I think that it was the middle of the psychiatric treatment, in the middle of it, he told me that he didn't want to take more medication and he was very angry because I was trying to give him more medication and he didn't want that.

So the cooperation, the therapeutic alliance was less ... was beginning to be different then, yeah.

Q. So there had been challenges, I guess, in general terms, and we'll get into the medication aspect, but ... so

there had been challenges with Lionel Desmond throughout his period of time at the stabilization phase?

A. Yes. Yes, because I'm looking at the documents I have here and I can see that on the 16th of June, I tried to give him some more medication because he was still anxious during the day and he was very angry at me, didn't want to have more medication then.

Q. Okay.

A. Yes.

Q. And we're going to discuss that more. First, I'd like to turn to ... I apologize, Your Honour. The exhibit number I don't have in front of me.

EXHIBIT 254 - STE. ANNE'S HOSPITAL - COMPLETE MEDICAL RECORDS - LIONEL DESMOND

It's exhibit number 254. This, Doctor, as you're familiar with, is the entire Ste. Anne's record as it relates to Lionel Desmond but, in particular, if we could turn to page 16. Do you have that in front of you, Doctor?

A. No, I don't. Page 16?

Q. Yes. If you don't have it in front of you, I think we have it up on the screen. Can you see that?

A. Yes, I can see that on the screen, yes.

Q. I'm just going to ... So, Doctor, it shows here, it says, "Problem sheet - May 31st, 2016". So this is the first date you would've met with Lionel Desmond?

A. Yes, that was the first time I met him, yes.

Q. And this is your report as it relates to that initial meeting. Is that correct?

A. Yes, this is my initial report. It's a report that is made for all the patients we see and it is kind of a resume of the diagnosis.

Q. So, Doctor, if I could ask you to sort of indicate, what was the initial diagnosis that you made of Lionel Desmond?

A. Well, the first one is PTSD. Severe intensity and chronisized and linked to a mission in Afghanistan in 2007. This was the first diagnosis.

Q. Okay.

A. The second ... yes?

Q. If you could run us through the diagnosis and then we'll go back to each one. So what is the second diagnosis you made?

(10:50)

A. The second one was major depression chronisized, and relied to the PTSD. And the third one, the third one was

dependence to alcohol in recent remission. And the fourth one, personality traits from mixed features.

Q. So, Doctor, I guess we'll start with the first. So on May 31st, you were able to come up with that diagnosis and there were four categories as it relates to his principal diagnosis. So you reached that conclusion. Did you reach that independently of any prior diagnosis?

A. Yes, I did. It was my own diagnosis but I realized that some of those diagnoses had been made before by other professionals.

Q. And I just want to go over that. So when Lionel Desmond had entered Ste. Anne's, did he have a pre-existing diagnosis of PTSD?

A. Yes.

Q. Did he have a pre-existing diagnosis of major depression?

A. Yes, he did.

Q. Did he have a pre-existing diagnosis of alcohol abuse in remission?

A. Yes.

Q. And did he have a prior existing diagnosis of traits of mixed personality?

A. Well, I cannot answer to that because I don't have the file here. This was my diagnosis but was it the diagnosis made by his treating team? I assume so but I'm not sure.

Q. Okay. I'll help you out a little bit. I will indicate, and the Court is well aware of the record, that the diagnosis of traits of mixed personality, this is the first time we had seen this from any psychologist or psychiatrist in Lionel Desmond's ...

A. Okay.

Q. ... medical records. So I guess if we start with the diagnosis of post-traumatic stress disorder, you link it to his mission in Afghanistan in 2007. And I guess how was his PTSD diagnosis linked to that mission in Afghanistan? I wonder if you could give us examples.

A. Well, because I questioned him about his mental health in general, I could go to his ... the previous ... was it treated before his mission? Did he have mental illness previous to his mission? And I could see that there was nothing there. He has never been treated before. This is in my report. And then I could see with him during the assessment that he has had traumas, multiple traumas, during his mission, and I assumed that the PTSD was due to that, to the traumas during the

mission.

Q. And, Doctor, you used the phrase "severe chronic intensity". So I assume you can have PTSD but PTSD without severe chronic intensity, is that correct?

A. Well, those are two different terms. PTSD can be light, it can be moderate or severe. In his case, there were severe symptoms of PTSD.

Q. And so ...

A. And "chronic" is another term saying that it can be acute, it can be, it just happened now, but after a while, after many years, it can become chronic, you know, it's always there.

Q. So if you can explain to us, in as basic terms as possible, what made Lionel Desmond's PTSD to rise to the level of severe chronic intensity? What was it about it that gave it another category of severe chronic intensity?

A. Well, it was severe because the symptoms were severe. He didn't sleep well, even with medications. He was always tired. He was very depressed. No interest in sports and activities. Very retired at home. No friends. And we could see that his social life was really very inexistent. We could see that he didn't eat well. He was by himself. He didn't have friends. So this made the symptoms much more severe. He had

flashbacks. He had what we call dissociations. So ... and his functioning in a normal life - work, with friends - it was really, really bad.

Q. And what did you mean when you said he had flashbacks and dissociations? What did you mean by that and what were some examples?

A. Well, flashbacks, it is a dissociation. When a patient with PTSD is triggered by something, sometimes it's smell, sometimes it's a vision on the TV, it's a vision of violence, hearing ambulances, for example. So they are easily startled and they can relive the events, the traumatic event, and they are dissociated. They are not there anymore. They are in the event and they live real fear and anxiety then. And this is a flashback.

Q. And is this something that Lionel Desmond was experiencing on a very frequent and recurring basis?

A. Yes, he was. And during my assessment, I realized that there were odors, for example, noises, seeing Arabic persons. Those things were triggering him and making him relive the traumatic situation. And then that's why he would react with avoidance. He didn't want to go out, to go to places where there are crowds. He didn't want to be reactive to those.

Q. So, Doctor, the fact that his diagnosis of PTSD was severe chronic intensity ...

A. Mm-hmm.

Q. ... in your experience, is that going to present more of a harder road to sort of get through? It was going to require some more work, some more intense treatment? Is that fair?

A. Yes. It can mean that, but if the patient cooperates, then it can be treated well. For example, with the medication, with treatment in psychotherapy, the patient can be helped a lot then if he cooperates well.

Q. So I'm just trying to gauge the level of his PTSD and the intrusiveness of the symptoms. You've treated many military veterans over your long career. How would Lionel Desmond rank in terms of, and I realize it's difficult to be accurate, but in terms of the severity of his PTSD symptomology? Where does he rank? Does he rank in the low end? The middle end? The high end? The exclusively high end? Where does he fall in that continuum?

(11:00)

A. I would say medium to high, yes. It's not not rare to meet people with severe symptoms at our level because you have

to know that when a military comes to us in residential they have been treated elsewhere for a long time. They have tried a lot of medication and treatments and then when they come to us usually we have the more severe cases. But in the case of Lionel Desmond it was severe but it was not unusual for us to see severe PTSD.

Q. Okay. I'm going to ask you about the chronicity and the intensity and how it impacted him directly. Did you get a sense of how the interplay of how PTSD was affecting his everyday life? For example, did it have any impact on his housing situation? Did you get any sense of that?

A. Well, he was not eating well. He was worried about the payments of his house. He was wanting to sell his house. He had difficulty to do that. He said he had money problems. Paying the bills, for example. He didn't have much at the end of the month to dispose of as money. He was very worried about finances and he was not eating well. He was rather isolated at home.

I must say that most of the time the patient suffering from PTSD, they try to isolate at home because they don't want to be triggered outside by the fact of seeing violence or ambulance or some kind of crowds. They are afraid to be triggered and to

live those (revivisance?) of the trauma.

Q. And in Lionel Desmond's case you did say there was aspects of him isolating at home, isolating himself from others?

A. Yes, I could see that.

Q. And had his trauma been active in sort of affecting him in terms of his employment do you recall?

A. Well, he was release in 2015 and I saw him in 2016. So I don't think he had been working. I saw in the report that he had been working a while but he had difficulty with his relationship with the other workers where he was. I saw that in the report yesterday. But this was not something that I talked with him during the assessment.

Q. And so consistent with his relationship with other people he was working with that he had difficulties with, did you get a sense of how his condition was impacting his social interactions with others?

A. Well, yes, the symptoms that he had were impacting a lot with his social life. He was not sleeping well. He was very tired and depressed. So he had all the condition to have difficulties with the social life.

Q. How was he at ...

A. And in the same time ...

Q. How was he at multitasking? Keeping appointments, lining up appointments, dealing with more than one state of affairs at the same time.

A. I cannot answer you for that because I ignored that, I don't know.

Q. Sure. And did you get a sense that his mental health condition was impacting his relationship with his wife, Shanna Desmond?

A. Yes, it was. That's what ... that was the first thing that he told me that he wanted to be a better husband and a better father, and that he was irritable at home, that ... which is a PTSD symptom. And he was irritable. He was ... there were a lot of problems with his wife. He made that the purpose of being with us in the stabilization. He wanted to get a better family life.

Q. So in your understanding, was that his main goal for participating in the Ste. Anne's program, was to better his relationship with his wife and more direct ... as well his daughter?

A. Yes.

Q. Did you ...

A. He was ...

Q. Go ahead.

A. He was always talking about his marital life more than talking about the PTSD symptoms. But the main purpose was to have a better interpersonal life with his wife, his daughter, and others, yes.

Q. And when you say that he spent more time talking about the relationship with his wife than even his PTSD symptoms, did it seem to you that in his clinical makeup that his home life with his wife and daughter was a primary compelling stressor in his life?

A. Yes, I can say that.

Q. And in your entire time with him up to June 26th was that a recurring theme, the struggle he had in the relationship with Shanna Desmond?

A. Yes. This was a recurring theme, yeah.

Q. And, Doctor, in your time with him up to June 26th did that ever seem to subside, the struggles that he was having as it related to that relationship?

A. Well, something happened around the 24th of June while he was staying at the residential program. His wife, his child, and ... they came to Montreal. They did a trip to Montreal and he had four days with them and he could see them. He could go

out of the hospital and be with them for four days. He was able to rent, I think, something, a hotel near the hospital. But he was seeing, also, an uncle and other persons of his family.

So something came up and he passed those four days with them and it went relatively well. And when he came back to the hospital he told the persons in the team that he has had a very nice weekend but he was ... at the same time, he was sad to see them go back home. But we could see that he wanted to improve the quality of his relationship with his family. Then we could see that.

Q. Did he have difficulties regulating his emotions? For example, if he became ... if something angered him that he was able to diffuse fairly quickly or easily or had sort of drastic mood swings, how was he at regulating his emotions that you witnessed?

(11:10)

A. Well, anger was a major problem for him and that's why he went to the residential program for anger management and for interpersonal relationships. And that was the work that was done there with him. But he had real problem with anger, with ... and that is why I said in my diagnosis that he was having personality traits because he had a lot of mood dysregulation,

you know? He was ... when he became angry, once he became angry, it was very difficult to try to calm him and to change the subject. Okay? So that's why ...

Q. How would you go about treating that? How did you go about trying to minimize that if he was hard to sort of keep calm and he was very dysregulated ...

A. Yeah.

Q. Deregulated ...

A. Yeah.

Q. How do you go about treating that and how ... as it relates to Lionel Desmond?

A. Well, I must say that the psychiatrist in the stabilization program is ... mean of treatment is medication. You can give a patient some medication to stabilize his mood, to address the stress ... stressors in the most stable manner. Okay? So that's why I gave him Topamax, which is a medication for stabilizing mood, the mood. It is very good medication, also, for PTSD. It is used by a lot of clinicians in PTSD. So we had a good choice of medication there but he refused to take it and ...

Q. And, Doctor, in your ...

A. Yeah?

Q. ... opinion, how important was Lionel Desmond's treatment for anger and regulation of his moods, how important was medication for Lionel Desmond, in your opinion?

A. It was essential. My opinion was that it was the first part of the treatment. He must have had a good medication to stabilize his mood and then after that other means - psychology, respiration, mentalization - in the residential program ... he would be more accessible to those kinds of treatment. But the first part was medication and that's ...

Q. And in terms of Lionel Desmond ...

A. Yes.

Q. When he walked out the doors on August 15th, in your opinion, was medication and the continuation of medication essential for Lionel Desmond's stabilization and getting this anger and regulation of moods in check?

A. Medication was still essential then. He accepted to take some medication. For example, he was taking medication for sleep. He was taking zolpidem. It helped him a lot. He was taking Seroquel also, which helped a lot also. Seroquel XR, which is Seroquel acting ... XR means extra-long release. Acting all day. And those medication helped him. He was sleeping better. He was much less depressed. The depression

was gone I can say because he had interest. He was doing bicycling all the time. He was playing guitar. He had a better mood.

So he had improved on some symptoms but on the anger management he still had problems. And medication would help him a lot. I felt that being in the residential program they could make him accept more medication but he did not. So the work was still to be continued at home with his team over there.

Q. So I'm going to ask you a little bit about that but I want to review the medications first. So you indicated Topamax was for what purpose?

A. Topamax for mood regulation. It is given because it helps on anxiety but mostly on those mood, you know, when a patient suffers from PTSD they are easily startled, irritable. So Topamax works on that very well.

Q. And did it have some success with Lionel Desmond in reducing his irritability and anger?

A. Well, he took it only one day.

Q. So I'm going to ask you about that.

A. So I couldn't ... Yeah.

Q. So you prescribed it, you thought it would be helpful and you say he took it only one day. Why did he only take it

one day?

A. Well, I'm not even sure if he took it one day. He was ... I could see in the nurse's report that he didn't trust this medication. He looked at the pill and he didn't want to take it. So the nurse called me and told me he didn't want it. So I didn't insist. I just stopped the medication stat. It means do not take it now. And then I tried to explore that with him after that.

Q. Did he seem receptive ...

A. I tried to con- ... no, not at all. He was very angry at me for bringing up the subject. He didn't want to take medication. He become angry. He became even a little aggressive with me and then I saw that he had personality traits and that's why I said after my assessment that there were paranoia traits in him.

Q. What do you mean by he became aggressive with you when you were trying to convince him to give Topamax a try because you thought it would be helpful in his symptoms of anger?

A. Yeah. Well, he told me he didn't want to talk about medication. He told me that ... the phrase he used, I remember it quite well, and I did put it in the file in my assessment. He said, Doctor, don't take the Desmond out of me. Meaning

"demon". Desmond. Don't take the Desmond out of me because something can happen. And I saw that he didn't want at all to take medication or more medication. And I decided to wait a little because he was not in a good mood then.

And after that he still told me ... he still ... he told me that he had taken marijuana in the past and it didn't help him. He didn't take it for a long time. And all the medication that he took were having side effects and he wouldn't take any more medication so ...

(11:20)

Q. So I just want to back up a little bit. You said he said, Don't take the Desmond out of me, or, the demon out of Desmond? What ...

A. The Desmond.

Q. What did you under- ...

A. The Desmond.

Q. What did you understand that to mean?

A. Well, I understood that he didn't want to take medication, more medication at all, and it was impossible to discuss the medication with him at that moment because he would become more angry. And I decided just to wait the right moment to talk about the medication once more after that.

Q. And when you said he said, Something will happen, is that what he said to you?

A. Yeah.

Q. And in that context what did you understand he was referring to?

A. Well, I don't know what he meant but it was kind of a way for him to say, I don't want to speak about that, I'm going to finish the interview and go back to my room.

Q. So did you ...

A. Something like that.

Q. Did you interpret ...

A. I didn't feel he was ...

Q. Go ahead.

A. ... threatening me, no.

Q. Okay.

A. Yeah.

Q. But his resistance to medication and how he would become angry about the topic of medication, did that cause you some concern from a clinical perspective?

A. It was a real concern for me because if we want the patient to be stabilized we have to give him the good medication. We have to give him antidepressant, for example,

for the depression. We have to give him mood stabilizer. In this case it was mood stabilizer. We have to give him that if we want his mood to be calm, more calm, more easy in his personal relationships. We had to give him some medication to sleep, to ... Just in case he would have a panic attack, he would have to take something.

We have this medication that we can give to a patient just to stabilize him so he will be able to meet stressors of life without outbursts.

Q. So you felt, clearly, that medication was important to get to Lionel Desmond's stabilization.

A. Yeah, seeing how he reacted this day, I was convinced he needed medication. Absolutely.

Q. And in your opinion, Doctor, in the time he spent from May 30th to June 26th, although you did at some point say you saw various improvements, was it your opinion that he became clinically stabilized or was that still something that was left ongoing?

A. Mm-hmm. Well, I think he was stabilized in a way because he was sleeping better, because his depression was gone. He was more active. He was talking with other patients. He was active in sports, playing guitars. So the depression was

better. The sleep was better. He had more energy. So he was improving and I think this is the way environmental therapy works, you know? He was in security with other members of the Canadian Forces.

This improved him but as for this part, PTSD, irritability, mood disregulation, then he needed medication. Absolutely.

Q. How important was medication going to be when he walked out the doors and into the community on August 15th? How important was it going to be for his stabilization in the community and going forward?

A. Well, I think there were work to do with that after that, but I didn't see him then because we don't see patients when they are in residential program.

Q. And I appreciate that but you know, as his treating psychiatrist at Ste. Anne's, that he's not going to be there forever. And you know that medication is important to his continued stabilization as it relates to anger and regulation of moods and irritability.

A. Mm-hmm.

Q. Would you have liked to have seen that Lionel Desmond was going to be in contact with a psychiatrist in the community, for example, that was going to either prescribe him the

appropriate medication or at least discuss that possibility with him?

A. Yes. Well, each time we have a patient with us, at the end of his treatment with us we have a conference, a conference call, with the team, for example, in this case in New Brunswick. And our team and their team meet and they share the informations and they send the papers for that.

So it must have been made, but I wasn't there. I think it was made on the 9th of August. As I could see in the file it has to be ...

Q. So the recommendation ...

A. Yeah.

Q. ... that he continue with medication in the community was made is your understanding?

A. I cannot say yes because I didn't see that but the other members of the team can tell you if yes or no. Yes.

Q. That's fair. I'm going to ask you about the other medications and his reactions to those. So we discussed Topamax and then ...

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

MR. RUSSELL: Yes.

THE COURT: Dr. Ouellette, we started at around 9:30 and it's ... at least Halifax time, and it's about 11:30 now. We would normally take a break, and I was just going to ask you whether or not you'd like to take a break for maybe 15 minutes or so or come back if you're prepared to. Otherwise we would just continue through for about another hour before we broke. Your choice.

A. I will be glad to take a break, Your Honour, yes.

THE COURT: All right. That's fine. So we'll break for maybe about 15 minutes or so. Maybe about quarter to 11 your time we'll see you back on video. Thank you.

A. Okay. Thank you.

COURT RECESSED (11:28 HRS.)

COURT RESUMED (11:47 HRS.)

THE COURT: Mr. Russell?

MR. RUSSELL: Hello again, Doctor.

A. Hello.

Q. Hi. So I'm taking you through the various medications. We talked about Topamax and his resistance to the concept of even taking Topamax. I'm going to move to Sublinox. So what was Sublinox for?

A. Sublinox is for sleep. It's ... the name is Zolpidem

and zopiclone. I think the patient had taken zopiclone before. Almost the same medication. It's given to trigger rapid sleep. Usually, it acts for four or five hours but it helps very much the patient to sleep.

Q. And did Lionel Desmond take that while under your care?

A. Yes, he did.

Q. Did he have a similar resistance to that medication or a desire not to take that medication?

A. No, he accepted that, he did. I believe he had taken other medication for sleep before and this he accepted.

Q. Did he report to you any side effects or complaints as a result of that medication?

A. No.

Q. Moving next to prazosin, what was that prescribed for?

A. Prazosin?

Q. What was that prescribed for?

(11:50)

A. Prazosin is ... it's not a medication for ... to treat mental problems. Prazosin is a medication, it is an alpha blocker. It is designed for hypertension. It acts on the blood pressure, but giving that to the patients, we realize that they

have less nightmares, so when a patient has nightmares, we give prazosin usually at lower dosages first, but we increase the dosage until the patient has a better sleep with less nightmares. And we know in psychiatry, for PTSD, that nightmares are very difficult to tolerate for a patient because the nightmares are extremely vivid. The person becomes agitated during the sleep, sometimes so agitated that they can hurt the persons with them. And in the case of Mr. Desmond, I began with two milligrams, wanting to increase the dosage. We can increase it until 15 milligrams, but in the case of Mr. Desmond, he didn't want to increase it. He just stayed at two milligrams, I think, or ... I would have to see. It was one milligram at first and then two milligrams.

Q. So did you observe any sort of success with prazosin and Lionel Desmond? Was it helpful, in your judgement?

A. Yes, it was very helpful. He slept better and he had less nightmares. He could show less fatigue in the morning while getting up and doing his things, yes.

Q. In your opinion, would you have liked to have seen the increase in that dosage? Would you have liked to seen Desmond not resistant to that idea?

A. Well, at two milligrams, he showed improvement. It

was okay for me. It was okay because he had less nightmares, yes.

Q. Seroquel XR, 50 milligrams. What was that used for?

A. Seroquel is a typical antipsychotic. At high dosages, it is given for psychotic reactions or schizophrenia or difficult conditions, severe conditions. But at low dosages it helps to sleep at night and it also lower the anxiety. So when I gave him Seroquel XR, extra-long release, which is the basic ... you don't have Seroquel at a lower dosage. This is the basic. So I intended to raise it until the patient showed better concentration, lower anxiety, but he didn't want to raise it at all.

Q. So were you ever able to prescribe Seroquel in the way that you found it would be most effective?

A. No. It would have been more effective at 100 or 200 milligrams but I could not try that. He didn't want that.

Q. Did he eventually stop taking the Seroquel at 50 milligrams or did he continue at that dosage?

A. He continued. He continued until his release from the department of stabilization and I cannot say if he continued after that. I don't ... I was not there.

Q. And you say that he did express some resistance to the

idea of increasing the dosage.

A. Yes. He didn't want at all.

Q. And as well, Seroquel, 25 milligrams. What was that used for?

A. Well, it was prescribed three times a day, but it was what we call a "PRN" because I didn't want to push the patient, you know, to press him to take this medication, but it was good ... it is good for anxiety, for example, mood dysregulation. It would have been good for him to feel less anxiety and then be able to manage his entire personal encounters better, to be able to meet stress in a better way.

Q. And did he take that medication?

A. I don't think he took it. For example, I've seen in this file that the nurse gave him some Seroquel when he had this weekend with his family, and when he came back he gave her back the Seroquel. He didn't take it during the weekend. Maybe he didn't feel stressed but it would have been good for him to take it to feel better with his family.

Q. And overall, Doctor, do you think, had he been more compliant with medications, that it would've been helpful with his stabilization?

A. I think so. I think that if he had taken the right

medication, it would have been ... he would have showed more progress in the residential program and, after that, at home.

Q. We're going to move back to your second diagnosis, moving on from PTSD. The second principal diagnosis you have is chronic major depression related to PTSD.

A. Mm-hmm.

Q. I wonder if you could explain to us what that was as it relates to Lionel Desmond.

A. Yes. Well, it means that the patients with PTSD have ... in his case, there was several severe symptoms. No sleep, fatigue, no interest in activities, no sports, no friends. So with these conditions, the patient gets depressed, you know. He is not stimulated by others, he doesn't eat well, or sometimes they eat too much. He's not interested in activities that helps them to feel better. So they become very depressed and inactive. And that's what I wanted to say, saying that the PTSD was related to the depression. The PTSD and the symptoms of PTSD were conditions for the depression.

Q. And you said that this was chronic in nature, so ... and I understand it as ...

A. Chronic.

Q. ... more frequent, I guess, than major depression.

A. Yes. Major depression, we can say it's chronisized after a few years, when it's always there. So after a year or two, if there are ... if there is depression and symptoms of depression, we can say it's chronic.

(12:00)

Q. So were you, in your opinion, of the view that Lionel Desmond had suffered from major depression for years?

A. Mm-hmm, yes, I could say that.

Q. And, Doctor, what sense did you get, how was his chronic major depression impacting his day-to-day life?

A. I think he didn't have a day-to-day life. He was isolated and he had a lot of symptoms and he said he was not eating well. He told me when I assessed him that he was ... For example, I always look at that in my assessment. He wasn't ... that his weight 2,000 ... 206 pounds a few weeks before and then he was 192 pounds when I met him. So he had less weight. He didn't eat well at home. He was away from his wife and kid and he was not active. He didn't have activities - theatres or things to help him have a better mood, you know. Yeah.

Q. So I'm going to move to ... you diagnosed him with alcohol abuse but you indicated that it was in recent remission. Did you get a sense ...

A. Yeah.

Q. ... of how frequent was his alcohol use? What level was it at?

A. Yes. Well, when he came back from his mission in Afghanistan, he began drinking more and more, and in my assessment, he told me he was drinking 12 beers a day and it was ... it had become a problem. At some point, he said that they gave him cannabis and that he stopped drinking and taking cannabis instead, and he didn't like the effect of cannabis on him as he didn't like the medication effect on him. It was ... and he stopped taking cannabis before coming to our program. So he had stopped, I think, a few days before, and he didn't know if he would take back cannabis when he would go back home. So ... yes.

Q. At some point, Doctor, I'm going to ask you a specific question about your opinion on cannabis as it relates to Lionel Desmond but I'm going to wait until you discuss the diagnosis of mixed personality.

A. Okay.

Q. But I will go back to that specific question. So from your expert opinion, did the fact that he had a history of alcohol abuse, would that have had a compounding effect on his

PTSD and his chronic major depression?

A. I think so because alcohol and cannabis can have depressant effects on people. Cannabis can have effects on the cognitive conditions of a person, and in the case of Mr. Desmond, it could have had depressant effects and the effects on his cognition, you know, attention, concentration, maybe memory. And that's why people taking cannabis don't drive. So in his case, there already, I had noted that his concentration was bad, so it would not be a good idea to take alcohol or cannabis.

Q. I'm going to move to your fourth principal diagnosis and I'm going to spend some time here. The fourth principal diagnosis, traits of mixed personality. So clinically, what are traits of mixed personality?

A. Okay. Well, you see, personality in a person is a way of adapting to the outside world, the reality. It's a way ... in a normal person, the personality helps him to adapt to stressors or things in their reality, but when we have a person with personality traits, it means that they are more rigid. They adapt less well to their reality, to stressors, and they do that in a specific way. For example, some people have obsessive- compulsive traits of personality. So they are always cleaning, always arranging things. But other persons may have

paranoid personality, okay, traits. So with traits, they are more suspicious of others. They don't give ... they don't trust others so easily. They have doubts about others. Maybe they have some doubts about the spouse. They can have jealousy or be mis- ... have some ... they don't trust the others so well. They are suspicious. So this is paranoid.

And then you have other traits, borderline traits, schizoid traits, and it is not so important as a personality trouble. When you have a personality trouble, you have the whole problem, you know, it is intense and severe. So ... and usually begins at the end of adolescence or early adulthood.

So you have personality trouble. They begin very early at life and it's a way of being with others, really severe. And then you can have personality traits, like what I said for Mr. Desmond, which is a less severe condition, but it is a condition colouring the frame, you know, colouring the life of the patient. And then, in the case of Mr. Desmond, I thought and I saw that there were paranoid traits.

Q. Now that was going to be my question. What were the mixed personality traits and what were the paranoid traits?

A. Yeah. Well, in the case of Mr. Desmond, there were obsessive-compulsive traits. He was cleaning all the time.

They gave him a task to clean the kitchen, to clean the ... he liked to do that a lot and he was really angry seeing persons putting dirty feet on the floor. Things like that. And he also had a paranoid personality disorder. So that's why we see mixed. There are traits of many - sometimes two, sometimes three - type of personality. Why did I say that for paranoid personality? It is ... the fact that Mr. Desmond ... there ... it was really difficult to gain his trust, to gain a therapeutic alliance with him. And, for example, giving him medication to improve. This was really quite impossible with him. While he was with the nurses and with other persons, he would not give them his trust easily. He would be ambivalent, okay? Should I stay in the stabilization program or go back home? He was ambivalent about that and he was easily angry if someone would contradict him and he had problems in controlling his emotions.

(12:10)

So that's why this was said about him. It was with a diagnosis. I understand that a psychologist ... I recommended a psychometric test for him to have a detailed vision of his personality, and I understand that Isabelle Gagnon, the psychologist, the health psychologist we had, did some testing with him, and although it was in the residential program after

that, she arrived to almost the same conclusions as me. She said he had personality traits. She talked about borderline traits. I talked about the paranoid traits, but we had the same conclusion about the traits of personality.

Q. Is there a difference between borderline traits and having personality traits?

A. Some of the symptoms are almost the same, but there is a good difference between both of them. In the borderline traits, someone always feels fear of being rejected. They have outbursts always. Anger is omnipresent in their state of mind. They can be paranoid too. They can have some paranoid thoughts.

So in both, we can have the same features, but essentially, the borderline presents himself in another way, okay? He can have ... he can be very, very glad and feeling great one day with some person, and then the other day, it's a contrary. He feels very low and very ...

Q. Did you observe any of that with Lionel Desmond?

A. With Lionel Desmond, I observed mostly that he feared to be ... to trust the other persons. For example, if two persons talked together, he would think that they were talking about him. And during the time he was in the army, he was alone, he was rather isolated, and when he tried to work ... for

example, he tried to work after he was released from the army and then he was having difficulties with the other persons working with him because they were not acting properly for him in this sense, yes.

Q. So you indicated here, you said, "Traits of mixed personality", and you described how they could involve paranoid personality traits. If I'm recalling correctly, did you say Lionel Desmond had paranoid personality disorder?

A. No. It was paranoid personality traits, not disorder, because to say that it was a disorder, you have to go back in his history and know exactly how he was behaving as he was an adolescent and in early adulthood. "Disorder" means it began a long time ago.

Q. And these personality ...

A. I did not feel those were from ...

Q. And these personality traits and paranoid personality traits, did you get a sense of whether they were independent of his trauma experienced in Afghanistan? Were they existing separate and apart from military trauma?

A. Yes. The personality, the traits of personality, are independent of the PTSD and I could understand then why the treatment had been difficult with him. It was because of those

personality traits. You see, when we see patients with PTSD, they often have, or almost all of the time they have what we call comorbid diagnosis, okay? So we have someone with PTSD, but also he has depression, he has anxiety problems, he has alcohol problems, and he can have personality traits. All those conditions, comorbid conditions, interfere with the PTSD, and then we have to treat the comorbidity before treating the PTSD. And those comorbid conditions, they have symptoms of their own and it can relate with the PTSD. It can worsen the symptom of PTSD.

So with some patients; for example, a patient who has a real personality disorder, the disorder is so intense that it is difficult to treat the PTSD, okay? So we have to do something with the comorbidities before treating the PTSD. But anyway, that's why the medication is very important because ...

Q. So in Lionel ... Go ahead.

A. Yeah. And if the patient is not medicated, it's going to be very difficult to treat the comorbidities and to have therapeutic alliance and treat a patient, yeah.

Q. So in Lionel Desmond's case, were his mixed personality and paranoid personality going to factor into the difficulty in treating his PTSD?

(12:20)

A. Yes. Indeed.

Q. So if Lionel Desmond was sent to a psychologist to be treated for PTSD, in your opinion, was there more to be treating Lionel Desmond than just simply psychotherapy for PTSD?

A. I think so. I think that psychotherapy could be aimed at the PTSD, yes, but in the same time, he needed to be addressed for comorbid features in his case.

Q. Could you get a sense of how long those personality and paranoid personality traits were present in Lionel Desmond? Could you get a sense ... I realize you can't trace it back forever, but did you get a sense of when they would've developed and when they came to be? Were they always there?

A. I have a sense that, with the PTSD, with the intensity of the PTSD, his personality traits were worsened, I think, yes. They could have been there for a long time, but under pressure, under ... with the PTSD, they could have been worse.

Q. Did you get a sense of how his personality and paranoid personality traits impacted his relationship with his wife and daughter?

A. Surely, because they are around him all the time and he was surely very symptomatic, so with the PTSD, we have a lot

of symptoms. For example, irritability. I have here hypervigilance, startling reaction, problems with concentration, difficulty ... irritability, for example, is very high and it can be very, very difficult with the persons around you, yes.

Q. What about issues of trust as it came to, say, Shanna Desmond in the relationship?

A. Mm-hmm. Yes. Well, with paranoid traits, you can have jealousy, you can have doubts about the spouse fidelity. So this is important ... an important factor in those cases. They doubt everybody. They doubt their spouse, they doubt their best friend. They don't ... they will not make confidence to others because they fear it's going to work against them and sometimes they perceive aggressivity from others without motive. So their interpersonal reactions are quite uneasy and especially with the spouse ...

Q. So Doctor ...

A. ... because she is the one ...

Q. Go ahead. Especially with the spouse ...

A. Because they live together.

Q. I'm going to conclude this bit about mixed personality traits with sort of two questions. One, what was the ... in your opinion, what level of insight did Lionel Desmond have into

his condition generally and his condition about having mixed and paranoid personality traits? What was his level of insight and understanding?

A. He didn't have insight of that. He began to say, I think I have PTSD. While he was with us, he began to say that, but at the same time, he was saying that his condition might be due to head concussions and that he should treat himself with neuropsychologic treatment. He had a treatment in mind and this was not at all the treatment for PTSD so ...

Q. How were you going to go about treating his mixed personality and paranoid personality traits? How would you go about treating it?

A. Well, medication was the key and it always has been my opinion that he should have taken medication. When he went to the residential program, he would have group therapy about medication and I was hoping that the psychoeducation about medication, I was hoping that the fact that he saw other patients taking their medication, would help him to change his mind, but it didn't change his mind during the time he stayed with us. So this has to be done after his departure from the department and with his treating doctor at home. But no one can give medication to a patient who says no. It's impossible.

Q. Would it be important for Lionel Desmond to have someone perhaps, like you had said, a doctor at home in the community that would actively encourage him to take medication?

A. I think that the work had to be continued with his family doctor or his psychiatrist at home. I'm not sure he would have changed his mind because he was categoric with me. Yes, I'm not sure.

Q. Do you think ... I realize I told you I was going to ask two questions. I'm almost done here this morning, Doctor.

A. Yes.

Q. Do you think, without taking those medications and in the community, did Lionel Desmond sort of pose a risk that he would quickly destabilize?

A. I ... it's ... I cannot answer this question because I saw him only at the stabilization program. I saw that he became angry talking of certain subjects, like medication or sometimes money, but to what extent would he react at home, I cannot answer that. It's impossible. But he was easily upset when avoiding subjects he didn't like. This, I saw.

Q. I think, Your Honour, that's sort of a natural stopping point, subject to the Court, obviously.

THE COURT: No, thank you, Mr. Russell.

Dr. Ouellette, we would normally break for lunch. It's 12:30 here. It may be just a late brunch for you in Montreal. I guess it's only 11:30, but we are going to take a break for perhaps an hour and then resume this afternoon, if that's agreeable to your schedule, hopefully?

A. Okay.

Q. All right.

A. Yes.

Q. Thank you, Doctor. So we'll get back to you sometime within the hour.

Maybe about 12:15, 12:20 your time, if you could be around your computer and we'll re-establish the link.

A. Okay.

Q. Thank you very much.

A. Okay.

Q. Appreciate your time. Thank you.

A. Have a good appetite.

Q. Thank you.

COURT RECESSED (12:29 HRS)

COURT RESUMED (13:31 HRS)

THE COURT: Mr. Russell?

MR. RUSSELL: Good afternoon, Doctor.

A. Good afternoon.

Q. So where we left off, we left it off our discussion with mixed personality traits. I'm going to take you to page 15 of the report from Ste. Anne's.

A. I don't ... okay.

Q. Do you see that there, Doctor?

A. Yes, I see it.

Q. I'm just going to read it so it's ... this is a report that was done by you. Correct?

A. Yes, in a way. It is an administrative procedure and it's probably a clerk that took the file and filled the report with the diagnosis I had made.

Q. Okay. So I'm just going to read to you first the diagnosis, the number of things. It says: "Post-traumatic stress disorder, mental and behavioural disorders due to the use of alcohol dependent syndrome, low back pain, tinnitus, severe depressive episode without psychotic symptoms, mixed personality disorders and other personality disorder, paranoid personality, anxiety disorder unspecified." So is that an accurate description of the various diagnoses and mental health stressors Lionel Desmond had?

A. No. And it was not me who filled this diagnosis. I

don't know where it comes from. Probably ... I really don't know but I would adjust the terms of the diagnosis. It is mostly accurate but I would say it in another way. Maybe if I can see all the diagnoses, I can help you with that.

Q. Yes.

A. For example, post-traumatic stress disorder, we can add to that, severe intensity. That's what I would have put.

Q. Okay.

A. Mental trouble. Well, for the alcohol, we can say: "Abuse and utilization of alcohol in recent remission". Okay? Remission.

Q. Okay.

A. The lombalgie, acouphenes, those are medical diagnoses made by Dr. Richer probably.

Q. And is that lower back pain?

A. Yes, lower back pain. And "acouphene" means tinnitus, it means having something in the ear, you know, noises in the ear due to the ... probably the military work. So those two are medical diagnoses, physical problems.

Q. And any other corrections?

A. And then ... yes. "Depression severe." When the patient went at the ... to the residential program, I would have

said, "Depression in amelioration."

Q. And what do you mean by that?

A. I mean that he was less depressed than when he came to the department, so we can say, Major depression in partly ... with partial amelioration. Okay?

Q. Okay.

A. He was not as depressed anymore as when he came.

Q. Okay.

A. And then "Troubles mixies de la personalite." "And other troubles of personality." As I told you, he didn't have the intensity of a personality trouble then. It was, we can say, personality traits, mixed personality traits. This would have been the right way to say that.

Q. Okay.

A. Mixed personality traits. And then we can add (French term) and paranoia traits because "personalite paranoiaque", which is down is not accurate for him.

Q. Okay. So it would be ...

A. I don't know what ...

Q. So just to correct it. So it would be personality traits as opposed to personality disorder?

A. Yes.

Q. Okay.

A. I don't know where they took those diagnoses and why they did it that way but it's not accurate.

Q. And finally, Doctor, where it says, "Anxiety disorder unspecified." Is that accurate?

A. No, because the anxiety was coming from the PTSD and the depression. So it was specified that the anxiety was coming from something specified, the PTSD.

Q. Okay. I just wanted to correct that particular page of the record based on your testimony and based on your actual report.

My question is this, Doctor. I guess we're guilty of some ways of referring to Lionel Desmond as a military veteran who was struggling with PTSD and really only discussing PTSD as the source for all of his difficulties.

A. Mm-hmm.

Q. Is it fair to say that Lionel Desmond's was much more than that? The complexity of his condition was much more than PTSD?

(13:40)

A. Yes, it's true to say that because with that, he had what we call comorbidities. He had personality traits, mixed

personality traits. He had depression, he had alcohol abuse, and he also had marijuana consumption, medically prescribed. So he had some comorbidities with the PTSD. It was not only PTSD.

Q. So, Doctor, in terms of an ultimate treatment for Lionel Desmond, did it go further than just he needs treatment for post-traumatic stress disorder?

A. Mm-hmm. Yes, he needed treatment for the ... all the ... of what he got, but we had to begin with the comorbidities and treat ... yeah.

Q. So, Doctor, I'm going to ask you a question about cannabis being prescribed medically. Knowing what you know about Lionel Desmond and the comorbidities - post-traumatic stress disorder - would you have ever prescribed him cannabis?

A. First of all, we don't ... I don't prescribe cannabis to my patients because in Quebec, we don't have the right to do that. We have to have a license to prescribe cannabis. And Medical College of Quebec asked us not to prescribe and it gave permission to certain physicians to prescribe cannabis as a part of research on cannabis. Up to now, we don't have the right to do that, but if I had the right to do it, I'm not an expert in that. I don't ... I would have to study the subject. But what I know from the patients that I see taking cannabis and

medication together, I can assure you that the cannabis would not have been an indication for Mr. Desmond because Mr. Desmond showed a lot of problems of attention and concentration, sometimes memory, and we know that cannabis can influence attention and concentration and memory and it would have augmented his problems with cognitive problems. So it was contraindicated with him.

Q. How would the consumption of cannabis impact his mixed personality traits and paranoid personality traits?

A. Well, being less concentrate, being ... having less attention, then his interpersonal relationships would certainly have been different, but I cannot go farther than this with him. I would have to be there. I would have to see what was going on with him taking cannabis. He didn't take cannabis at the hospital and I would have had to observe it, you know. I cannot ... but the literature tells us that cannabis can aggravate the cognitive impairments in patients and I believe that.

Q. And, Doctor, so I'm going to bring you to page 41. We'll pull it up on the screen and it's under "Reasons for Admission". Do you see that, Doctor?

A. Yes, I see that.

Q. Now obviously I'm going to read this in English and I

hope it translates.

A. Okay.

Q. I hope it translates well.

A. Okay, I'll listen. Okay.

Q. You indicate that he has side effects of most drugs given since it continues to be very symptomatic. He is referred to the stabilization program and residential program for an in-depth assessment and for medication adjustments. Do you see that?

A. I see that.

Q. And was that the main purpose for his admission to Ste. Anne's? Medical adjustments and an in-depth assessment?

A. It was, yes. In the program of stabilization, this was the reason for admission.

Q. And, Doctor, at page 42 under "Medical Surgical History", it notes that Lionel Desmond described to you a past history where he might've fell into a hole while he was injured and injured his spine during service. Do you recall that?

A. Yes, I see it, yes.

Q. Did you notice anything with Lionel Desmond that would show maybe a neurocognitive deficit?

A. Well, during his staying with us, it was observed by

me and by the team that he had neurocognitive problems and I mean by that, attention or concentration or sometimes organizing his appointments, being late at meetings and things like that. It was observed and that's why, because we were aware that he has had accidents during his missions or his work, we decided to ask for him a complete neuropsychometric test to evaluate this. Those psychometric tests could not be done at Ste. Anne's Hospital because it requires to be done by a special psychologist specialized in neuropsychology. So we recommended it to his team so it would be done when he come back home because it takes a long time to do those tests, in many days, you know. It's questions and charts and he has to answer to a lot of tests before having the opinion about that, yeah.

Q. I understand. So Ste. Anne's didn't have the capacity or ability to do that test while he was there?

A. No. There were no neuropsychologists in Ste. Anne's at that time. And then we recommended it, but usually it takes a few weeks before receiving a response for that. So we prefer to tell the team in place and to suggest for them to do that with the patient.

Q. So, Doctor, I'm going to have you turn to - and we'll bring it up on the screen - page 261.

A. Mm-hmm.

Q. This is a report of social worker Kama Hamilton. She is a social worker, as you know, with the Ste. Anne's clinic.

A. Yes. Very, very ...

Q. You're familiar with ...

A. Very dedicated. Oh yes. Very good, yes.

(13:50)

Q. So I'm going to read to you the last paragraph that's on the page. It says "Observations". Now these are observations in a report by Ms. Hamilton. It says:

> With the new information of the head trauma experienced by Mr. Desmond, the writer believes there is a possibility of cognitive or neurological damage that may be contributing to his difficulties with impulse control, mood swings, difficulty with judgement, et cetera. We'll discuss this with interdisciplinary team Tuesday, August 9th.

So you see that passage, Doctor?

A. Yes, I see it.

Q. Do you agree with the observations of Ms. Hamilton

that head trauma perhaps could be influencing impulse control, mood swings, difficulty with judgement?

A. Well, yes, but my opinion is that seeing those neurocognitive impairments in the patient, I would've thought that it was very important to rule out physical lesions that could explain that. But in the same time, you can have those cognitive impairments with the PTSD, with the depression, with the alcohol abuse, so the neuropsychological testing would help us to know what was with the PTSD and what was with the possible concussion. But I was a little surprised. I was asking myself, did those tests were made ... were those tests made while the soldier was still active member of Canadian Forces, because when this happened to him, he must have had some kind of assessment or treatment for those. We didn't have those informations, so it was ... the best thing to do was to ask for neuropsychological testing just to clear out this problem.

As for my part, I think that the neurocognitive problems that he showed might have been from PTSD as well as concussions, you know. We had to rule out the factors influencing this.

Q. And consistent with that, if we could turn to page 14.

A. Yes.

Q. So I'm mindful, Doctor, that this is not your ... I

guess page 13, sorry.

A. Okay.

Q. I'm mindful ...

A. Yes, this is the ... yeah?

Q. And I'm mindful that this is not your report. This is the report of Dr. Richer?

A. Dr. Genevieve Richer. Dr. Richer is the omnipractitioner responsible of the residential program, and when a patient as is released, she makes a final note in which note she puts the diagnosis she finds in the file.

Q. So, Doctor, I notice that under "Other Diagnoses", she has listed as number two ...

A. Yes.

Q. "Former cranial and cervical trauma." Do you see that?

A. Yes, I see that.

Q. Do you know if that was confirmed through any medical documentation or as a fact that he had former cranial and cervical trauma?

A. I don't know that. This is the medical part and I don't know what ... in my assessment, I said that he fell on the ... in the hole, 10-foot high, and ... but it was the patient's

words for me, you know.

Q. Okay. Go ahead.

A. Yes. Dr. Richer has made ... in her first note of the patient, once she saw him for the first time, it was on the 9th of June 2006. It was not "d'admission medicale" - note of medical admission. She said that too at the end of the page, she said, "Trauma cranien" - cranium trauma - "... possible at the occasion of a fall with neuropsychologic deficits non-exclude," not rule out a fall on the back from height of ten feet. So she noted that then too.

Q. So this is ... is this ...

A. And ...

Q. ... consistent with your view that it warranted further exploration of whether or not there was ...

A. Yes. Indeed. And Dr. Richer noted the same thing.

Q. If we can look to page 14 - we're going to go back to medications for the moment - it says, "Departure medication". She has listed, "Prazosin, Tylenol, Seroquel XR 50 milligrams, Seroquel 25 milligrams, Sublinox 10 milligrams." So did you understand that these were the medications that were going to be recommended for when he left Ste. Anne's?

A. Yes, it was and it was the medication from me and from

Dr. Richer together.

Q. So ...

A. For example ... yes.

Q. So going forward, did you want to see him take those medications when he was in the community after he left Ste. Anne's?

A. Yes, yes.

Q. And why?

A. It was the same medication. Well, because he was taking it in Ste. Anne and, well, it was not the medication, the ideal medication for him, but coming back home, I was hoping that his psychiatrist at home would give higher dosages of those medications because it was very low dosages.

Q. If we could turn to page six of the Ste. Anne's records.

A. Page six?

Q. Doctor, we're looking at a letter that appears to be ... can you see it on your screen?

A. Yes, I can see it.

Q. We're looking at a letter that appears to be written by you on September 1st, 2016, and addressed to ... who is this addressed to?

A. Centre ... authorization centre for the medication in ... it's located in Charlottetown or (inaudible) now. And when we have to ask the permission to give some medication to a patient, we have to write them, ask the authorization, and then the patient can go at the pharmacy and buy the medication because most of the psychotropic drugs which are prescribed to our patients are given by the pharmacist, but some new medications are not on the list. So if we want the patient to have this special medication, we have to write a letter and ask permission to give it to them, and then they will receive it. It's a matter ... it's non-administrative processes, but sometimes it gives problems to the patient because at the hospital, the patient ... for example, this prescription of Sublinox, at the hospital, he received Sublinox all the time. There's no problem with that, but when he come out of the hospital, when he comes in his community, then the pharmacist will say to him, This medication has to be accepted by VAC. So they will ask his psychiatrist to write a little letter to accept it, okay? And there are delays. And sometimes the patient might pass a few days without the medication.

(14:00)

So what we do at the residential program, we give a

prescription of the medication to the patient and we give the patient one month in advance of all his medication. So when he comes at home, he has the medication for one month and he has also an appointment with his psychiatrist. We make sure that he has an appointment, a date, when he goes back home, and he meets his psychiatrist and this process is done. The psychiatrist writes a letter and asks for the medication at VAC.

So that's why I did that in this case was that the patient went back home and he didn't seem to have met his psychiatrist, or I don't know if ... what happened, but they asked me to write the letter so he could have the medication, which I did graciously because it was not me, the treating psychiatrist, it was someone else. But I did that so the patient could have his medication readily.

Q. Do you know who asked you to write the letter because there wasn't a psychiatrist in the community to write that letter?

A. I think that the nurse at the admission committee asked me to do that.

Q. The nurse ... where was it? From where?

A. You know, before we admit a patient, there's a nurse gathering all the information and calling the ... This nurse

asked me ... well, she told me, He doesn't have access to Sublinox. Would you write the letter while he is trying to see his psychiatrist? So I don't know what happened. I tell you this from ... it might have been this, but I'm not sure, but what I am sure of is that the nurse asked me to write the letter, yeah.

Q. And, Doctor, just so I get this straight. So Lionel Desmond left Ste. Anne's on August 15th. You send your letter September 1st, 2016. Did the request for you to write the letter happen after Lionel Desmond left the clinic, after he left Ste. Anne's?

A. Yes, it was done after that, but we have to remember that when he left the hospital the 15th, he had one month medication. He had Sublinox for one month. So it's to help the patients. Sometimes they don't have ... they don't have the occasion to meet their psychiatrist sooner, so in the meantime, they have their medication, and when they meet their psychiatrist, then he gives them a new prescription.

Q. And in the normal course of things, this type of letter ... I just want to get this straight. In the normal course, this type of letter would come from a community psychiatrist that he would've seen after he left Ste. Anne's?

A. Yes. Yes, because the psychiatrist in his area is his treating psychiatrist. It's not me who is his treating psychiatrist when he goes back home.

Q. If we could turn to page 44. So, Doctor, this is again your report. If we go to the third paragraph and I'm just going to read you that passage. It says:

> In the house, the gentleman therefore developed a lot of irritability with his family. This is the reason for the couple's separation and near breakup. Reportedly (it refers to Shanna Desmond and it was redacted) called the police a few times because of irritability. No legal consequences have taken place. The gentleman feels great sadness at the loss of confidence in his family.

Was that a consistent theme with Lionel Desmond that he was disappointed in his relationship with Shanna Desmond throughout his stay?

A. Yes. Well, it meant that Mr. Desmond was preoccupied with his family. He wanted to improve the relationship with his wife and little girl and that's why he accepted to come in the

stabilization program, to improve his personal relationships and he didn't want this to happen anymore. That's why.

Q. And I'm just going to read you the rest of that paragraph.

> He hopes that the current treatments will improve his relationship. He doesn't want to part with his little girl. He would have had suicidal thoughts before but he got rid of his guns at home and he says he no longer has any suicidal thoughts now.

A. Mm-hmm, yes. Well, we always, during an assessment like this, we ... first, we want to know if the patient has suicidal thoughts or suicidal plans and then we make sure that he doesn't have arms, firearms, at home. And in this case, he told me that he didn't have arms at home, firearms at home, anymore. And he told me also that he didn't have suicidal thoughts. I think he was right because he was hoping to improve when he came at the hospital with us, but nothing can prove me that there were no firearms at home. It was his word that I had to take.

Q. And in the context of when he told you that, did you understand that to be he had suicidal thoughts before and,

therefore, that's why he got rid of his guns?

(14:10)

A. Yes. I can understand that. You know, I think I saw somewhere that he did have suicidal thoughts before and it happens all the time with our patients. Sometimes they did try to suicide themselves, but usually, we ask them not to have firearms at home.

As a matter of fact, at the outpatient clinic where I work in Ste. Anne, the nurses who see the patient make sure that they don't have firearms at home or they would take their firearms, give them to someone they trust, and keep their firearms under key. So for almost everybody. And there is a directive at Ste. Anne, no psychiatrist or doctor is going to sign papers to say that someone can buy some firearms, okay?

For example, I had a patient who came to me asking me, Would you sign this paper so I can buy a firearm? And the directive at the PSO is you don't sign this.

Q. And why ...

A. It was not like this before. It was not like this before, but since two years, it has been the direction told us not to sign anything about firearms.

Q. So just so I understand this, so since this occurrence

with Lionel Desmond, psychiatrists at the clinic of Ste. Anne's have received a directive not to sign off supporting firearms?

A. Oui ... yes. This is the directive and some patients don't like that at all because some like to go hunting or doing things with their firearms but the directive is there. And sometimes they go to see their treating physician to sign ... for them to sign it.

Q. Do you know who is ... do you know which person is the person that's giving the authority or the directive? Who is telling you not to do it?

A. It's ... well, in the case of the outpatient clinic, it's Josie Pierre which is the clinical administrative coordinator. She gave us this directive.

Q. And that's for ...

A. She is the head of the outpatient clinic, yes.

Q. What about inpatient?

A. Inpatient, what we do when a patient comes to us, the nurse goes through his or her luggage, everything is screened. If there are knives or arms or things with what the patient can harm himself, they are taken and kept in a locked room, and then the patient gives his car keys also and sometimes the car is "fouille" in French. I don't know. They search everything in

the car so there is no firearm there. So the patients are well aware that they cannot bring arms or firearms or knives with them in our departments, and if there is suicidal thoughts, I even think they take their "ceinture" ... you know, their ...

Q. Shoelaces?

FEMALE: Belt.

MR. RUSSELL: Belt?

A. Shoelace- ... the belt, yes.

Q. And ...

A. So ... yes.

Q. So, Doctor, in terms of the directive comes from her on an outpatient basis, but is there a similar directive to you if, say, a patient that's inpatient wants to get you to sign off on firearms, do you have a similar directive not to?

A. No, because we cannot substitute to the treating team at home. At home maybe they are ... they have different directives. When he is with us, he has to act as we do with our patients, but when he comes back home, he becomes again the patient of his team and then there might be different directives.

Q. So, Doctor, I'm going to read this line again and I'm going to ask you a question about it. You said, "He ..." It's

on page 44. "He would have had suicidal thoughts before, but he got rid of his guns at home." Did you understand from what Lionel Desmond is telling you that he felt that he shouldn't have firearms?

A. I'm not sure. I cannot answer your question because I don't know why he got rid of his firearms at home, who asked him to do that. Was it the police when they went to see him at home, when her (sic) wife called? Was it coming from him? Was it coming from his wife? You know, I was not there and I cannot give you an advice on that. And he did not give me his version when I saw him in assessment.

Q. So, Doctor, I'm going to ask you the question and I'm mindful of the fact that you're seeing him at a period of time. When Lionel Desmond was in your care at Ste. Anne's between May 30th and June 26th, knowing what you know about Lionel Desmond, do you think he should have been able to possess firearms or was there a concern there?

A. My opinion as a psychiatrist is that he should not have had firearms because he had real problems with anger and he should have undergone anger management and anger treatment before having firearms.

Q. Were there any other ...

A. I would not have accepted that, yeah.

Q. Were there any other things that you would say and observe that would've gone into that assessment or made you believe he shouldn't have firearms? Anything else?

A. No. No.

Q. If we could turn to page 45. Doctor, in terms of treatment plan and recommendations in your report from May 31st, where Lionel Desmond is going to be admitted to the stabilization department, you say "possibly" that he may be admitted to the residential department. What do you mean by "possibly"?

(14:20)

A. Well, I have to look at that. Well, when a patient comes in stabilization, we have to make an assessment and many observations of the patient with (the authors?) after that. The assessment is there to make a diagnosis, but after that, we have to see if the patient collabores with the other patients. How is his mood? Does he have suicidal thoughts at times? We have to make some observations. If our observations are okay, then he can be admitted at the residential program, but if something comes up and he's not collaborating well and he is angry, he is threatening other patients, he is not able, for example, to do

group therapy, then we will sit with him and try to see other types of treatment possible in his community.

We won't admit a patient that can't be stabilized. The other patients in the ward because those patients in the ward have PTSD also and they are really anxious about violence, anger, and it can destabilize them very much. So we have to observe the patient when we admit him. We have to observe his ... is he collaborating well with the medication? Is he able to concentrate and do group therapies? So if we make those observations of the patient and if the patient fits with our criterias, then we admit him, but we cannot say we will admit him absolutely. Some patients do only stabilization and they go back home. It's a possibility.

Q. And so clearly, Lionel Desmond must have reached some level of stabilization because we know he did go to residential.

A. Mm-hmm.

Q. Were there still aspects of his stabilization that needed work even after June 26th?

A. Yes. Well, as a matter of fact, I was ambivalent about the fact, should he stay with us or should he go back home? And I told them ... that to the team because he didn't want to take any more medication. He was not entirely

stabilized. So I told the team, What can we do with that? And that's why, if you see my notes, on the 14th of June, I ...

Q. Page 48.

A. ... I said ... yes. 14th of June, I said ... I added Topomax to his medication, and on the 16th, I had another encounter with him, in which encounter he told me that he didn't want to take the medication. He told me not to take the beast out of him, the Desmond, the beast out of him, and he showed those paranoid traits. So I was less and less interested in accepting him in the residential program and I told the team. I told that to the team. That's why, on the 23 of June, the next note, I saw the patient. I saw Mr. Desmond with Isabelle Gagnon, who was the coordinator of the program, and Julie Beauchesne. We went to see the patient, three of us, and we discussed with him about the fact that he didn't want to take medication. What did he want to do? And we realized then that he had improved, that he was sleeping better, having less nightmares. He was motivated to do good work in the residential program. Even if he didn't want to have medication without that, he would benefit from the residential program and then maybe we could have him accept to take more medication because in the residential program, there are group therapy for

medication. The nurses and the person doing the group explain what is the medication, what are secondary effects, if there are some, and they explain ... they try to convince the patient to take the medication regularly.

So without that, this psychoeducation, would help the patient to change his mind, which it did not finally. And that's why, finally, he was admitted to the residential program.

Q. So just so I get this clear, at various points during stabilization, you had real concerns as to whether or not Lionel Desmond was stabilized to move to the residential phase.

A. Yes, indeed. And it is because when he came to see us at the stabilization program, he had said to the nurse, admission committee, he had said that he would accept medication changes and to take medication. And when he came to us, he didn't want. So it changed a lot of things.

To my experience, a patient who doesn't want to take medication, who doesn't cooperate with that, it is really very, very hard to treat a patient like this.

For example ... I will give you an example. You have a real headache, okay, and your doctor says, Well, with this medication, your headache is going to go in one day. And you say to your doctor, No, I won't take medication. I don't want

to take medication.

So if you come back two days after that saying to your doctor, My headache is still there and I suffer a lot and the doctor says, Well, you should try this medication and you don't want to take it. What can we do? And it's the same thing with a patient suffering from PTSD. With a lot of symptoms - anxiety, problem with dreams and sleep and fatigue and depression - if we say to him, This will help you a lot and then you will be functioning well with that, and he doesn't do that, a week after that, it's going to be the same thing. And the improvement is not going to be there. He will try to improve with other techniques, and in the residential program, there are techniques like that - group therapy, yoga, psychoeducation, art therapy, there are ... they can improve with that, it's good, but this is not ... the medication is absolutely necessary too at the start ...

(14:30)

Q. And was that ...

A. ... to stabilize the patient.

Q. Was that one of the most difficult things with Lionel Desmond was the non-compliance or not wanting to take medication?

A. I think this was the most difficult problem because I am sure that if he would have taken the medication, his relation with other, his anger, his depression would have been more under control. You know, the emotional dysregulation would have helped a lot I think ... I am sure it would help. To what extent I don't know, maybe it should have been adjusted with time and ... but usually it helps a lot.

Q. Can you think of clinically, was there any benefit to Lionel Desmond having someone that could encourage him even when he left and went home to sort of keep on top of the importance of taking medication? I realize you can't force someone but ...

A. Yes. Yes, well, the Canadian Forces have good ... very good solutions for that. They have what we call the peer support. Other soldiers, you know, soldiers who have undergone mental problems and they can go to the patient's house, they can help them in eating better, they can be friend with them and then try to convince them.

And usually the military men and women, they are very open to someone who has been in the army before, you know. So they accept that quite well and this is a very, very good thing. I think that we would need more than ... us, at Ste. Anne's, we have only one but we would need more, I think one or two. But

this is a good solution.

And also we can ask what we call ... we can prescribe ... like a support from a professional ... clinical support. It's a professional who goes at home once or twice a week to help a patient to take the medication, to do his shopping, to pay his bill and who can help him in his daily activities, this is extremely good and to take the medication.

Q. Would this be a role of sort of an occupational therapist perhaps?

A. Yes, some ... I don't have the right word, it's a prescription of clinical ...

Q. Clinical care manager?

A. Yes, clinical care manager, "organisateur" in French, organization of clinical care. They go at home. They do a lot of good work with the patients, yes.

Q. So in your view, would it ... I take it to understand that Lionel Desmond when he returned to the community because medication compliance was so important that he would have benefited from peer support as well as a clinical worker to assist him.

A. Yes, I think so, and maybe it was suggested on the papers given to the other team. You know, there was ... I have

the date here, there was a conference with the team ... the New Brunswick team, and it was done by our team on the 9th of August, 2016. And I was not there because I was in stabilization, but usually they give all the information there. They give the suggestion of the professionals and the ... I think they give the prescription of neuropsychological tests for the cognitive problem. They must have done that, but I don't know. And I ... usually it's like that but we have to verify that.

Q. So while Lionel Desmond was at Ste. Anne's were you aware that he had at various points conflict with other residents as well as other Ste. Anne staff? That he had conflicts and difficulties and disagreements with them?

A. I was not aware of that. I was in the stabilization program and when they go to the residential program it's Dr. Richer who is in charge there, with the clinical coordinator. But if something comes up, they always can take a prescription and ask for a consultation with the previous psychiatrist.

I looked at my file and I didn't see a consultation that was written to me to see Mr. Desmond in the residential, so I cannot say what happened, no.

Q. So, Doctor, were you consulted by anyone at Ste.

Anne's while Mr. Desmond was in the residential phase? Were you ever consulted?

A. When he was where?

Q. At the residential portion.

A. At the ... other insti- ... No, I didn't have consultation from Dr. Richer or from the team then.

Q. Were you aware that there was various arguments with his wife on the phone while at Ste. Anne's? Was that brought to your attention? Were you aware?

A. I would have to look at my notes. He told me that there were problems with this couple. He wanted to be a better father. And what I did ... I have to look at that. What happened at the end of the month when he was supposed to go to the residential program, his wife and his little girl decided to come to Montreal ...

Q. Yes, you did mention that.

A. It was very important for me to see how it would go. We advised the patient that he could come back in the ward anytime during the weekend if something was not going well. And it was like a test, you know, to see how everything would go.

He had medication with him just in case and everything went well. He was glad when he come back ... came back. So it was

not there that I saw problems, marital problems. It was the social worker who were talking about that.

(14:40)

Q. Okay, that's fair.

A. Yes.

Q. Were you aware that at various points ... Aside from the conflicts you had with him about medication, were you aware that at different points he told other workers that he was going to leave the program?

A. Yes. I could see that now because I have the file and I saw that he wasn't sure he would stay in the program while he was in the stabilization program. Each morning when I came to see my patients, when I come to see my patient, I look at what the nurses say that happened during the day and the night and I saw once that he wasn't sure, he told that to the nurse.

So, yes, he was ambivalent but why? And this was a sign that he ... you know, when we talk of paranoia traits, he was not sure if we could help him or not. He was not sure if we were working with him or against him. He was not sure if his wife was ... had fidelity or not. He had such difficulties, but it's part of his personality traits.

Q. And in your opinion ...

A. Yeah.

Q. ... did he ever get that sense of distrust with healthcare workers, the distrust with his wife, the paranoid thoughts, did he ever get those under control in the time he spent with you to a satisfactory level?

A. It was not on control. But I am sure that if you questions ... question the other member of the team that saw him in the residential program they could answer to that. Was he able to have a real trust in them or was he always showing "mefiance" - I don't know how to say that in English - mefiance, mistrust, yes. There should have been that.

Q. And ultimately, Doctor, is it fair to say that one of your primary roles as the psychiatrist at Ste. Anne's was to reach some level of stabilization with Lionel Desmond?

A. Mm-hmm. This is the primary role and the other role I had was was he okay to go to the residential program. Was he fit for that? So in the absence of the medication we had to be very careful not to send someone who would upset the other patients on the other side.

Q. You've treated a lot of military veterans over the years, some I'm sure you saw the highest level of stabilization that you could possibly see, others perhaps no stabilization.

Where did Lionel Desmond fit on his level of stabilization when he left Ste. Anne's on August 15th?

A. Oh, on August 15, I didn't see him.

Q. Okay.

A. I didn't see him at that time, I was not ... I'm not able to say that. But when he left the stabilization program, it was 50/50, okay. He had improved with his sleep, with his nightmares, with depression. He showed some improvements, it was okay, and that's why he went to the residential program. But when he went home on June the 15th then I didn't assess how he was at that time.

Q. So when you say he was 50/50 where you last left off in the end of stabilization phase, was there a risk that Lionel Desmond could fairly quickly decompensate or lose stabilization?

A. Yes. Well, he was ... his personal interrelationships were good. He had some friends on the ward. He was doing bicycling, playing pool, eating with the others, so it was an amelioration, maybe we can say 55/45, something like that.

But what I did, I asked the social worker, Kama Hamilton ... At the end of his stay in the stabilization program I asked Kama Hamilton to contact Mrs. Desmond to have collateral informations about Mr. Desmond.

Because Mr. Desmond signed papers so his team at home, they were not able to talk to Mrs. Desmond because Mr. Desmond didn't want that. So we succeeded ... In Ste. Anne, we succeeded to convince him after he had seen his wife and kid, they came for a weekend, we succeeded to have his authorization so Kama Hamilton would call his wife and ask about details that we did not have.

And why? It was because I didn't want problems to happen in the residential program, okay. Was he violent? Has he been violent with her before? How was he with stress or ... So Kama Hamilton called Mrs. Desmond and Mrs. Desmond told us a lot of thing about Mr. Desmond's way of relating to her at home.

Q. Okay.

A. And finally, we took a good decision for Mr. Desmond and he went to the residential program.

Q. There are two things that I want to sort of wrap up with that I left unexplored. Did he report to you fairly frequent dreams of homicidal themes or thoughts?

A. Yes, he ... the first time I saw him, he said that he had dreams and the dreams he had were obsessions about his wife's fidelity, and then once he talked about a dream where he would kill her, you know, because he was angry at her.

So we know that in dreams the ... when someone is in anger

it goes ... it's like an explosion, there is no inhibition. He told me that once. It goes with the PTSD, but this dream he told me it was ... it was not usual ...

Q. What do you mean?

A. ... and he did ... Well, usually the dreams, the nightmares that the military have are nightmares relating to the trauma they had during mission, okay. Sometimes they see the enemy coming at them, trying to kill them or they are trying to kill the enemy but it's thing related to mission.

(14:50)

Sometimes when the person is having a very, very strong stress at home it's a mixed nightmare, things at home and things in the mission and violent behaviour or things like that. We can see that rarely but it happens.

So it didn't seem to happen often in this case and it was an indication that he was ... he was jealous, you know. He had a problem of jealousy with his wife and he didn't know if he could trust her or not. He was ... he did permit her to address ... to the finances of the home and then he would sign a paper saying, no, it's me who is going to do that, and then he would do it unproperly so she had to take control again.

This is ... when we talk "paranoide proces" this is what we

mean: trust/distrust, not knowing exactly if he can trust his wife. So this is my answer.

Q. So this paranoid traits and distrust of his wife and you said dreams that he would kill her ...

A. Mm-hmm.

Q. ... did they seem connected to his PTSD directly or could they be something else in his clinical portrait?

A. Well, I think it was kind of thing, this special dream, it was connecting to both. To the PTSD, because it was nightmare, and it represented what he ... the traumas he had lived in Afghanistan when he saw bodies in parts and a lot of blood. But also in this dream the anger with his wife and the doubts he had about her fidelity, so it's both, you see. Yes.

Q. So I definitely don't want to sort of leave an impression based on your evidence that everything is ... is it fair to say that not everything that Lionel Desmond was struggling with was PTSD related?

A. Yes. It's ... yes, it was PTSD related. It was depression related. But there were also personality traits and those traits were complicating the treatment a lot.

Q. Just one moment, Doctor.

And finally, Doctor, I'm going to ask you a question, it's

sort of a broad series of questions, but we know that Lionel Desmond is a black man from a rural community in Nova Scotia. We also know that he suffered occurrences of racism as a child and racism in the military.

How does that play into your overall assessment of him and the treatment? How does it factor in?

A. Mm-hmm. Well, we always take into account the fact that there are ... As a matter of fact, in the DSM-V there's always a chapter talking about, I don't know how to say that, but Culture-Related Diagnosis Issues. So about the culture. We have to take into account that some people come from other parts of the world and they have different ways of reacting according to their culture. You see here "Culture-Related Diagnostic Issues", it's with every diagnosis that we make.

In the case of Lionel Desmond, he ... I think he suffered of racism, I can say that he suffered. He felt rejected by his peer. And this was important in a way because this did cut him from the support of the other military men and women around him, okay. When someone is hurt, it's a good thing to have the support of the others around, but if the others around are aggressive or rejecting you then it can worsen your distress.

So we have to take this into account and I think it arrived

for him. Maybe it arrived when he was military ... at the military, active member, but this ... I say this because he told me some little things about that, but I would have ... the rest has to be lightened, yes.

Q. So you talked about Lionel Desmond's undercurrent of mistrust, he didn't know who to ...

A. Yes.

Q. ... kind of confide in, and you couple that with you talked about the importance of peer support. Do you think someone like ...

A. Yes.

Q. Do you think someone like Lionel Desmond may ... could have benefitted from a former veteran who was of the same heritage as him, of the same shared experiences, that he could see as sort of a peer support or a mentor in part of his rehabilitation? Do you think there's benefits to that?

A. Yes, I think it could have been. Yes, I think it would have helped him a lot, yes.

Q. And I'm thinking in the context ...

A. Yes.

Q. ... of you had mentioned earlier about the importance that someone kind of remind him that he could phone ... that he

could remind him to take his medication. If it was someone that he could relate to culturally and shared experiences ...

A. Yes.

Q. ... do you see the value in that?

A. Yeah, I see a big value in that. I give you an example. For example, those ten patients that we have in the residential and the stabilization program, many of them have gone to have "desintoxication", to have treatment in other types of treatments, you know. Portage, it's a place for the desintoxication, a place for treating PTSD.

But when they go there they meet not only military men and woman, but people coming from different backgrounds sometimes knowing nothing about the military and they don't feel at ease there.

(15:00)

But when they arrive at Ste. Anne, which is the only place in Canada where they are together for treatment like that, they feel at ease. They know that the other militaries are going to understand. They are not going to ask questions that can trigger them, you know.

So it ... maybe I take a long way to explain that, being the military men or woman to help someone this is extremely

good. And this has been done by the Canadian Forces for a few years and it has a good success. Maybe it should be more ... there should be more of this.

MR. RUSSELL: Subject to any sort of questions in a re-direct capacity, Your Honour, those would conclude our questions.

THE COURT: All right. Thank you.

Dr. Ouellette, I think what we're going to do is we're just going to take a short afternoon break for maybe 15 minutes and then when we return, some of the other lawyers in the room may have some questions for you as well this afternoon.

A. Okay.

THE COURT: All right. Thank you. So we'll adjourn for 15 minutes if we could. Thank you.

A. Okay.

COURT RECESSED (15:02 HRS.)

COURT RESUMED (15:17 HRS)

THE COURT: Thank you. Thank you, Dr. Ouellette. Mr. Russell, you're concluded? Mr. Anderson.

MR. ANDERSON: No questions, Your Honour.

THE COURT: No questions? Thank you. Ms. Ward? Ms. Grant?

MR. RUSSELL: I think, Your Honour, there was some discussion about the order potentially being adjusted.

THE COURT: Yes, all right.

MR. RODGERS: In the circumstances. We've concluded the order will be Mr. Macdonald, Mr. Rodgers, and Ms. Miller, and then it's sort of open at that point.

THE COURT: All right. Mr. Macdonald.

MR. MACDONALD: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. MACDONALD

(15:18)

MR. MACDONALD: Good afternoon, Dr. Ouellette. My name is Thomas Macdonald and I am the lawyer for the Borden family, so the late wife of Mr. Desmond and the grandparents and uncle of Aaliyah, his daughter.

I just wanted to ask you a few questions, Doctor, this afternoon. Is it fair to characterize your treatment of Mr. Desmond, that one of your observations is that he exhibited anger?

A. Can you rephrase your question, please?

Q. Sure, of course. As I understood your evidence earlier to ... and I'm putting the question in a different way,

but your evidence earlier to Mr. Russell, and I wrote it down. One of your comments was he had a real problem with anger, referring to Mr. Desmond.

A. Okay. Yes. The reason that he wanted and we wanted him to go to the residential program was to have anger management there and to learn how to control his anger. That was one of the reasons, yes.

(15:20)

Q. When you did the assessment of Mr. Desmond, did you find that that anger was often directed towards his wife?

A. No. I think his anger could be triggered by someone talking about missions, about contradicting him. I think this anger had been directed toward his case manager, for example, when she didn't want to pay for some ... the travelling of his wife. It could have been triggered by many things, including his wife, yes.

Q. Okay, thank you. Is it fair to say that despite the efforts from the team, all teams at Ste. Anne's, at the time Mr. Desmond left Ste. Anne's, his improvement, if I can put it that way, was minimal?

A. I wouldn't say minimal, but I would say, for what I could read, I think that he improved a lot at the beginning.

And then there were plus and minus, you know. It was dysregulating. It was up and down at the end when he was supposed to go back home. It was not a straight line.

Q. But, in fact, Doctor, I think ... do you remember one of the notes in one of the reports referred at the end of his treatment that he ... and Ste. Anne's appeared to be disappointed that he was exhibiting distrust of the team, if I can put it that way?

A. Yes, yes. I can put it that way. He was supposed to stay ... well, I cannot answer to your question because I was not there, but normally, persons stay two weeks more at the residential program. Why he left sooner, I think that some persons can answer that for me but I'm not the one who can answer that now.

Q. I understand. Doctor, and we won't need to turn to it unless you need to, but if you just bear with me with my question first. So there was an interdisciplinary discharge summary dated October 4th, 2016, prepared by Kama Hamilton with her electronic signature.

A. Kama Hamilton.

Q. And in that report, it, of course, collates a number of the findings of various members of the team. It's Exhibit

254 if you need to turn to it, Doctor, but I'm at page 268, but it's only if you need to turn to it. But you're familiar with the report in the sense you know what I'm speaking of?

A. Yes. The last report that everybody ... where everybody are writing their conclusions and their impressions and then their recommendations. Is this the report that you're referring to?

Q. Yes, it is. Doctor, did you ever have occasion to read that report?

A. I read the report but rather rapidly. I would have to read it better ...

Q. Sure. I'm not asking you to read it now. I'm just wondering if you had a chance to do it.

When I looked at the report, and as you say, it's findings from various members of the team, and close to the end of the report, there's a list of the people on the team and you're on that list. And my question is this, Doctor.

There's no specific section in that ... I'm calling it a report, but it's a discharge summary, an interdisciplinary discharge summary. There's no specific section in there from you and I'm wondering is there any reason for that? So in other words, a Dr. Ouellette section. There's not one in there that I

could find.

A. Yes, my name is there, but I am not a psychiatrist at the residential program, so it should not be there.

Q. Okay.

A. But usually, they send my reports with their reports usually. I think someone should ask the team, this team, they should ask them did they send my report to the doctors there.

Q. Going forward with Ste. Anne's treatment and documents and these kinds of reports in the future ... and I realize you're not a psychiatrist in the residential phase, but do you think it would be helpful if reports specifically flagged in sections, for example, a section from Dr. Ouellette in the stabilization program, a section, if it's applicable, to the patient who is leaving, dealing with ... if that person is experiencing domestic issues or their ability to possess firearms when they're leaving, so the next reader, the next treatment provider, would be able to sort of be flagged in advance, once they get that report that these are issues that could be something to look at? Would that be helpful, do you think, going forward?

A. I think it would be helpful to have the psychiatrist report, assessment, and the evolutio- ... not evolution,

progress notes, included in this report, yes.

Q. Okay.

A. It would be a good thing. But if you look at the structure of the stabilization program, at the end of the stabilization program, each psychiatrist makes a note, a resume, a summary, of the stay, when the patient stayed at the program, and it's called ... you see here, I don't know, it's on the 28th of June 2016. It's called "Ward Transfer".

Q. Yes.

A. And every time a patient quits the stabilization program, the psychiatrist dictates a note called "ward transfer" to explain the situation, the diagnosis, the reason of treatment, and then what happened during the hospitalization in the stabilization program, and then the treatment plan and recommendations. Here, it has been done, and then the medication. We ... you have two pages here and you probably have this in your notes ... in the notes. And each time the patient leaves the stabilization, we make a "redaction" of that, a summary of the hospitalization, and then this is put in the file, and I don't know if it's sent to the other doctors at home but it should be.

Q. Yes.

A. I think it is, really, but I have to ... it would be to verify that.

Q. Okay. Doctor, you mentioned earlier, when you were giving evidence with Mr. Russell, about the directive which is, I guess, about two years old at Ste. Anne's, that no doctors are to sign papers relating to firearms.

A. Allowing firearms for the patient, yes.

Q. Yes. Do you know ... do you have any personal knowledge whether that directive came about as a result of what I will call "the Desmond incident", subsequent to his stay at Ste. Anne's?

(15:30)

A. No, it was not because of that. I think that the question of firearms in outpatient clinic is a question I've seen since I was there and I've been there for ten years now. The nurses who do the assessment, the first assessment when the patient come, even before the patient sees the psychiatrist, the nurse, she follows a protocol, and in that protocol there's a section about firearms or other arms, and she asks the patient, Do you have firearms? Where do you keep them? Is it possible for you to give them to someone? If he has firearms. Can you give them to someone you trust? Can they be kept under ... with

a key, a lock? And then sometimes they ask the bullets should not be in the same room as the firearms.

Q. You mentioned in your evidence ...

A. So ...

Q. Oh sorry, go ahead, please. I don't want to cut you off.

A. So this is for every person. I understand that some people can have firearms at home but they are encouraged to do this, yes.

Q. Okay, thank you. You mentioned in your evidence to Mr. Russell - and I'm paraphrasing, I'm shortening up - that Mr. Desmond said to you, when discussing medications, words to the effect, Don't take the beast out of me. The word "beast" was used, I think?

A. "The Desmond." "The Desmond." "The demon ...

Q. "The demon?"

A. ... out of me."

Q. But "beast" too, though, or just "demon"?

A. "Beast" also, it was.

Q. Okay.

A. Yes, it was, because he was really angry. He didn't want to take more medication and that was his way of closing

this subject, yes.

Q. From a psychiatric assessment point of view, what can you share with us today? What was your impression at the time of his choice of words, the words "beast" and "demons"? Any impression with respect to that?

A. Well, my impression was that it could be that he had poor control of his aggressivity, that he had few words to express exactly what his feelings were, to put his feelings in words, you know, instead of saying aggressive things. And then I wanted to know if, in the past, he had been violent with someone - his family, his friends, and others. So that's why I asked Kama Hamilton to call his wife and to have a better review of his acting at home.

Q. And did you ever have occasion to ask him if he had occasion to be violent with his wife specifically in the past?

A. Well, in my assessment, I said that ... okay. I said here at page four of my assessment:

> At his house, Mister developed a lot of irritability in his family. This is why they were 'distanciated' from ... one from another, and there were almost separation with them. I think this is black here, you

know, because ... but I think it says 'Madame', 'Madame Desmond'. She would have called the police many times because he was irritated. No legal consequences happened but Mr. Desmond feels sad about those things and he wants the actual treatment to ameliorate the situation.

And then when I asked Kama Hamilton to call Mrs. Desmond, she said this here. Okay. She notes: "Also to note that her daughter is frightened when he yells, but that he has never been physically violent toward either of them and she has never felt that he would hurt them." So this was reassuring, you know. He would be angry, he would be irritable, but according to his wife, he never would hurt them.

Q. Thank you, Doctor, those are my questions. Thanks.

A. Thank you.

THE COURT: Thank you, Mr. Macdonald. Mr. Rodgers?

CROSS-EXAMINATION BY MR. RODGERS

(15:37)

MR. RODGERS: Thank you, Your Honour. Dr. Ouellette.

A. Hello.

DR. ROBERT OUELLETTE. Cross-Examination by Mr. Rodgers

Q. Good afternoon. My name is Adam Rodgers and I'm representing the personal representative of Cpl. Lionel Desmond. I have a few questions here for you.

A. Okay.

Q. Doctor, I just want to first situate the facility, Ste. Anne's, not physically but within the treatment complex. It seems that some veterans would come back from military conflict and just go home and be relatively fine, I guess we would say, from a clinical perspective. Some might come home and require a little bit of counselling and maybe some peer mentorship. Others may come and require longer-term counselling, and still others would require in-house treatment such as you provide at Ste. Anne's.

A. Mm-hmm, yes.

Q. And further to that, there are the cases such as Cpl. Desmond's where the stabilization period seems to be more difficult. So would it be fair to say then, of the potential cases that would come back from a combat situation, Cpl. Desmond's may have been one of the more complex and difficult cases?

A. The pathology we encountered with Lionel Desmond was a pathology that we see in a lot of veterans coming back from

missions or that are sent to us. The problem was the treatment itself, you know. Everybody that we see at the stabilization program undergo the ... begin the treatment the same way. We have a good assessment with them, we make observations of them, and then, according to our observations, we give them the right medication and then we observe their reaction with the medication.

(15:40)

For example, if the ... most of the patients sleep very, very badly and we give them something to sleep well, something not to arouse during the night, and this helps a lot because sometimes they didn't sleep well for years. So the therapeutic contract gains from that. Remember? They feel better and then they want to have more. And we go on with the medication.

We address the anxiety during the day because some of them are very anxious when they go ... for example, when they go out of the ward, when they go out of the hospital, because they don't want to face certain aspects of the things making them think of the trauma, okay? So we give medication for anxiety. Those are antidepressants. They are called antidepressants but in reality, they act well on anxiety. And then we go on with the treatment addressing the different symptoms. We cannot give

all the medication at once because if something goes bad, we won't know which medication has secondary effects. We give five medications and there secondary effects. So which medication does that?

So we go, one by one, and we take our time because the patient is there for a few months, and we make the observation. And then this is all ... finally, there is a stabilization in symptoms. The patient sleeps better. He is less anxious. He can concentrate better and his relationships with others are better because he can tolerate stress better. And then he goes to the residential program.

With Mr. Desmond, I think that if he would have entered the program this way, it could have been much better in the prognosis and in the amelioration of symptoms, no?

Q. Dr. Ouellette, thinking from the perspective of the soldier rather than the facility, they've gone through their own process, they've gone through some counselling, they may have gone through long-term counselling without things working, and now they've got a situation where they can go to a residential facility, and it must fill them with some hope that here, finally, is something that might work for me.

A. Mm-hmm.

Q. So it raises a question, when an individual that may be coming in with that degree of hope maybe doesn't establish and doesn't have the trust perhaps to engage in the stabilization process and take those medications. And so I guess one of my questions is, you know, what kind of insight can you give us into individuals that have that struggle?

A. Well, when this happens, we have to wait to establish a good contact with the person, try to gain his trust, his confidence, and then it takes longer time, much longer time, and sometimes it never happens.

Q. And it's fair to say, Doctor ...

A. But ...

Q. Oh sorry, go ahead.

A. Yes. But as you were saying, the case of Mr. Desmond is much more complicated because of that, but it doesn't mean that his symptoms, his pathology, is not reachable, is not treatable, you know.

Q. Would it also be fair to say that beyond a treatment program such as Ste. Anne's, there's nothing else? I mean what's next if this doesn't work?

A. Well, it depends on what you identify as a problem, okay? For example, in the case of Mr. Desmond, there were

personality traits, paranoid traits. So he should, he could, have been sent to a place where they treat personality traits. There are some in Quebec City. There are some in Montreal. There must be some around Halifax. Those are places where they treat personality problems.

As, for example, if you have someone taking alcohol, there are places where they treat alcohol problems, but if the person who has alcohol problems goes to a place where they treat anxiety, he won't have the right treatment there, okay? You have to choose the right place according to the good diagnosis.

Q. So are you characterizing Ste. Anne's then as a place that treats certain things rather than a place that treats certain people?

A. We treat PTSD and we treat depression and all kinds of stuff, but when a person has a big trouble of personality, it can be better treated elsewhere. We cannot treat everything. Because personality problems, it's chronic problems over years and it has to be treated in a certain manner, and as, in Ste. Anne, we have ten patients and it cannot be done with the others, you know.

Q. So the question I have then, Doctor, you talk about Ste. Anne's and there's ten beds there. Can I ask you just some

other broad questions about the facility? Roughly how many staff, how many psychiatrists, psychologists, would you have?

A. Okay. Right now, we have three psychiatrists. One of them is with us since a year and we are planning to do some work with people with drug addiction or alcohol addiction. So one of us psychiatrists is going to do some work with them. We have nurses, like, in every hospital. Every eight hours, they replace themselves. They put notes in the files of the patient and we can see what happened during the day. We have psychologists. In the stabilization program, there is one psychologist seeing one-to-one the patient every week. When he goes to the residential program, the psychologists do group therapy with them. It's not one-to-one.

We have addiction counsellor. We have physiotherapist. We have art therapist. We have "pedagogue" (auto?) ... pedagogist auto. I don't know if it's the right word, but someone ... psychoeducation. Someone for yoga. We have the doctor, Dr. Richer, which is an omnipractitioner. I don't want to forget ... We have ...

(15:50)

Q. No, that's fine, Doctor. I ...

A. We have an ergotherapist, massotherapist. Yeah.

DR. ROBERT OUELLETTE. Cross-Examination by Mr. Rodgers

Q. No, I don't need everybody. Just getting a sense of how many people are involved. It sounds like it might be 20 or ...

A. A lot of persons.

Q. 20, 25.

A. Yes.

Q. One building?

A. Yes. We are one building at the rear of the hospital and the ward is entirely for those patients. We have ten patients. Each has its room, and then there is a cafeteria for them only with a kitchen and things to make the cooking, and they have a television place for ... with a lot of ... ten chairs. You know the big chairs with the screen for TV. They have a place for internet, a lot of computers. They can contact their families. They have place for activities and downstairs there's a place to do some woodwork, wood carving, "menuiserie". They can do that there. And then they are provided with bicycles if they want to go around the hospital.

Q. All right, Doctor. And I take it from your evidence that this is somewhat of a ... this is a unique facility within Canada that treats exclusively veterans.

A. Oh yes.

Q. Okay.

A. Yes.

Q. Doctor, I want to come back to that in a moment but I want to ask a little bit about your analysis of Cpl. Desmond when you first observed him through the stabilization period, I guess. It seems as though you observed some dissociative episodes and you talked about a mixed personality disorder. I take it this was something of a ... it was observed in Cpl. Desmond but maybe not thoroughly flushed out, if I can put it that way, just over the course of a couple of meetings.

I guess I'd like you to, if you could, expand on what that diagnosis might mean and how it might manifest itself. You know, is it ... were you suggesting that Cpl. Desmond may have dissociative episodes that he might have ... there seems to be two types of dissociation. One where you, in your mind, are in a different place and another where you and your mind are a different person. I don't know if those are clear distinctions in your field or in your view, but which one would you say was Cpl. Desmond's?

A. Well, I think it was what we call a flashback, you know. The fact of being with a psychiatrist and talking about medication, he said that it was bringing him back to the trauma

he had in Afghanistan where he saw all those persons with blood, with death, and he had to take them and put them in the bodybag.

So this ... flashback is kind of a dissociation. He is not himself. He is over there with them. So this is another kind of flashback of dissociation. There can be dissociation when the person feels out of his body and not in control and other kinds, like you said. He feels that things are not real around him because of the anxiety. And there are other kinds of dissociation, yes, but with PTSD, we can see that.

Q. I wonder, Doctor, if, in your experience, you can talk about how that might manifest itself. In other words, would people act out as though they were back in a war situation and, you know, take out violence on someone that, in their mind, might be a combatant or something along those lines? Is that a possibility in what you see?

A. When they are in a dissociative state, yes, they can move, they can go around. I've seen once a patient dissociate and take his car and they found him back 300 miles away. This was a dissociation, yes.

Q. In this case, Doctor ...

A. But ...

Q. Oh sorry. Dr. Ouellette, in this case, we know that

in the final, you know, hours, Cpl. Desmond had visited a gun shop where he very calmly and patiently awaited his turn and purchased a firearm, returned home, got changed from nice clothes into camouflage clothing, drove into a woods road near his house, parked the car, walked through the woods, and then slashed the tires of his wife's new truck and entered the house.

So I don't know if you were aware of those details before, Dr. Ouellette, but does that in any way ... or can you make comment on that in terms of what we've just been talking about and dissociation and mixed personality disorder?

A. Well, no, I cannot because the only time I saw him in a dissociative state was in my office when I assessed him. And he calmed down rather quickly and everything was all right then, this, I can tell you. But I was not there to assess him when he did that and I cannot comment on that, no.

Q. Okay. Now, Dr. Ouellette, I understand that you had a limited, if any, role in the time around Cpl. Desmond's discharge from Ste. Anne's. Is that a fair statement?

A. Yes, that's fair.

Q. Now in the course of this Inquiry, we're looking at recommendations. Do you think perhaps you should be involved at that stage given that you make the initial diagnosis and just to

see how it's turned out and if things have been followed through upon?

A. Usually, there is a nurse at this meeting with the team and the nurse gives the vision, the psychologic, psychiatric vision. She has all the details of the medication. She has the diagnosis. She has the recommendation. Usually, it's her who would do that because we are not always there. I'm there only one-and-a-half days a week, so maybe I cannot be there at the time where there is this communication with the other team. That's why it happens like that, but there is no ... if the psychiatrist wants to be there, he can be there. It's probably more a question of logistic, you know.

Q. Okay.

A. If the "reunion", for example, takes place on a Friday afternoon, me, as a psychiatrist, I'm there only on Tuesdays, and Dr. Dallal is there on Wednesdays, and Dr. Sansfacon on Mondays. So we have to do something. And they send our reports usually.

Q. Okay.

A. But if we want to, we can be there, but it's a question of logistics, I think.

Q. Would the fact that he was so difficult to stabilize

and, in fact, did not stabilize, make you more likely to want to attend that discharge meeting?

A. I think he was stabilized in a way. He was not entirely non-stable. I think he had a 50/50 ... he was ... he had been improving a lot. He was 50 percent better but there were still work to do.

(16:00)

Q. There certainly was, Doctor. Some of the recommendations included that he, first of all, undergo a neuropsychological examination. There are others, such as going to a gym with a trainer, joining an art program.

A. Yes.

Q. Taking part in pet therapy, joining a cycling club, and engaging in yoga, practicing mindfulness, getting involved in his community, setting a regular schedule, and getting proper sleep. So those were recommendations, some of which may be good for anybody, but certainly specific to him, and there are quite a number of recommendations.

A. Okay.

Q. But I want to draw your attention more to Dr. Gagnon's comments and she says things like: He had a tangential speech pattern, that he cycled rapidly between extreme good moods and

anger leading to exhausted emotional numbing, that he had sleep difficulties and nightmares of his wife cheating on him, that he had interpersonal distrust with possible persecutory delusions, that he had difficulties assimilating information, he had cognitive rigidity, and an underdeveloped sense of his identity independent from his Canadian Armed Forces identity. So it seems, Doctor, that at that point ...

A. Who said that?

Q. This is Dr. Gagnon's ...

A. Excuse me.

Q. ... report. Dr. Gagnon's report.

A. Gagnon.

Q. Yes.

A. Okay.

Q. So, Doctor, it certainly seems, from reading these reports, that I'm not sure I would raise him up to 50 percent. In fact, if we were looking for success, it might be closer to zero than 50 percent, given some of those comments.

A. Well, this was at home probably. Maybe a lot of time after he had quit our department.

Q. Well, this was on his discharge. It seemed, Doctor, that he had some anger that was difficult to control and was

probably misdirecting it towards his spouse at that time.

A. Yeah.

Q. And there was significant relationship difficulties. So ...

THE COURT: Mr. Rodgers, I'm going to stop you.

MR. RODGERS: Yes.

THE COURT: Yeah. You're asking Dr. Ouellette about what Dr. Gagnon wrote ...

MR. RODGERS: Yes.

THE COURT: ... in his report. So at least maybe you could refer Dr. Ouellette to the document, to the page, if he wants to have a look at it and read it, because with your questions, you can really limit, kind of like, the background that might be important to Dr. Ouellette before he answers the question because you're really asking him to comment on Dr. Gagnon's belief versus what he saw earlier in his review and his estimation when he left the stabilization program.

The residential program was some number of weeks later, so you may, in part, be comparing apples and oranges, but I think, at a minimum, you should let Dr. Ouellette have a look at the document before you ask him questions that are based on it. Thank you.

DR. ROBERT OUELLETTE. Cross-Examination by Mr. Rodgers

MR. RODGERS: Thank you, Your Honour. Yes, it's a fair thing, Dr. Ouellette. These were not your comments at discharge. You weren't involved at that stage.

A. No.

Q. All right.

A. But who is Dr. Gagnon? Dr. Gagnon?

Q. That ...

THE COURT: I believe he's referring to Dr. Isabelle Gagnon.

MR. RODGERS: Yes.

A. Ah, Isabelle Gagnon, the psychologist. Okay. Well, Dr. Isabelle Gagnon was the clinical coordinator there and she gave ... she was part of the summary they did of the case, and she made her recommendation, but I was not there and it was not my department and I cannot answer your question about her comments. She could do that but I cannot do that myself.

Q. Okay, that's fine, Doctor.

A. I was not there.

Q. I accept that.

A. Yeah.

Q. Do you know, Doctor, who might be responsible for ... well, who has the responsibility to ask - I was going to say to

ensure, but to ask whether any services had been put in place for a patient upon discharge?

A. Can you repeat the question, please?

Q. So services that are recommended from the Ste. Anne's facility to ensure that those are in place or to ask whether those are in place prior to a patient being discharged, is that somebody's responsibility within the Ste. Anne's facility as far ... that you're aware of?

A. Well, I would say that Dr. Isabelle Gagnon, as the clinical coordinator, would be the one in charge for this because she's the one, you know, she's the one who has the authority for that.

Q. Doctor, you know, we're not here to assign blame and I'm not trying to ask questions with that in mind; in fact, the opposite, to maybe come up with recommendations for improvement. So that's the spirit this ... the spirit I'd like to have a constructive discussion on a few ideas or areas that we might explore.

A. Yes.

Q. One is holding ...

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

MR. RODGERS: Yes.

THE COURT: So "recommendations for improvement" depends on what you're looking at because recommendations for improvement may be beyond the scope of this Inquiry, particularly when, if you're looking at recommendations that go to the operation of federal agencies.

MR. RODGERS: Yes.

THE COURT: Okay? You know it's a serious question as to whether or not I can make recommendations directed in that way and whether I should even be permitting exploration of subject matter that is just focussed on that particular outcome of recommendations as it relates to federal agencies.

So appreciate that there is some overlap between what we will legitimately look at in terms of the terms of reference and that I can look at from a jurisdictional point of view, and what we necessarily touch on as it relates to Cpl. Desmond and his experiences.

So I'm not going to stop you, but I'm just going to ask you to be circumspect in the manner in which you ask your questions. Appreciate that there is that limitation.

MR. RODGERS: I do appreciate that, Your Honour, and I will make my best attempt to make sure that those questions are

directed to areas that are covered by the jurisdiction of this Inquiry.

THE COURT: Between the guardrails.

MR. RODGERS: Yes.

THE COURT: Thank you.

MR. RODGERS: Thank you.

Dr. Ouellette, I'm thinking of how, you know, if somebody asked to be released, generally, there's freedom to allow ... you know, a person can leave. There must be circumstances whether either you don't want to let them leave, you don't think it's safe, or you're considering transferring them to a provincial facility if they are returning to their home area. I guess, how do you navigate that issue if you're sending somebody home or if you're sending them to another facility that would be a provincial facility? Is that a circumstance that you've had to deal with?

A. Well, I didn't have to deal with that when Cpl. Desmond left the hospital. This is for sure. He was not under my care. But I can assure you that every patient from our ward who leaves the ward has to be seen by a clinician so they can investigate if he is homicidal or suicidal. Nobody quits the ward if there is a danger for the person or for other persons.

So this is done by a clinician in the ward where the patient is and it is written in the file. For example, the nurse would say, I've seen the patient. He's not suicidal or homicidal. And then the decision is taken by the authorities.

(16:10)

Q. Okay.

A. If something happens, if the patient says, I want to kill myself, I am suicidal, then he won't go. Something will be set in place for him to be treated. Usually, they are treated at the nearby hospital because in our ward, we don't have the facilities to treat them, but they go there and they don't have the choice.

Q. Okay. Thank you, Doctor. Just a couple of more topics, couple of more points.

There's an indication ... it seemed as though the team was able to get some valuable information from Mrs. Desmond, from Shanna Desmond, and that contact was valuable. Has the facility ... or have you thought about more ways to bring the family into the treatment program, perhaps even to have the family present in the facility for a number of days or a week or something just to make them aware of the treatment that is taking place so that they could be better prepared, for example?

A. In the residential program, there is one day expressively for the spouses or the husband and they come in the morning and they stay all day. And they do activities and they ask their questions and there is psychoeducation about PTSD and depression and what to do on medication. This is a must. Each time, there is a ... it is a must.

Sometimes, the spouses or husband, they don't want to do that. We have to respect that. But usually they come, yes.

Q. Okay.

A. It is imperious. And then if we have a patient in our practice who has marital difficulties, financial difficulties, we can take a prescription and send them to the right professional to help them. I do that in my outpatient clinic, yes.

Q. Very good. Thank you, Doctor.

So, Doctor, finally, can I ask is there anyone at Ste. Anne's with whom Cpl. Desmond would've dealt with, with whom he could identify from a racial perspective? Whether it's a treatment provider or a fellow patient? Any other African Canadians; African Nova Scotians, in particular, or even other Nova Scotians?

A. I don't know that but I know that he had one or two

friends and they would play pool, do bicycle, play guitar, and I don't know if they were men of colour or white men. I don't know that.

Q. Okay. But nobody on staff that would identify as such?

A. On the staff, yes, there are a lot of nurses, black, and Chinese. Yes, it's a very cosmopolitan. Haiti ... the Haitians. (Matimaw?), he was Vietnamese. There are a lot. There was one Latino. A lot of persons coming from everywhere in the world.

Q. It strikes me, Doctor, that this facility that serves the entire country might be something that could be replicated in other locations. Here in Nova Scotia, where we have the highest per capita population of veterans and military members. Is it your view, from your position, that this facility would be possible to replicate in different locations?

A. I don't know. I have no opinion now for that, but I think that we don't have to forget that those veterans, those military men and women, when they are active in the CF, they meet a lot of other persons from everywhere in the world and from everywhere in Canada. So there are black communities, there are Chinese, Latino.

In the army, you can have a wide range of persons, and in the outpatient clinic where I work, the names tell us that there is a lot of persons from many communities and I think it helps them to keep together, you know, to develop friendship, and it doesn't seem to be a problem with them.

Q. Just wondering, Doctor ...

A. Maybe ex- ...

Q. Go ahead.

A. Maybe except for some persons but it's my opinion. It's not an expert opinion but ...

Q. I just wonder, Doctor, if, you know, one of the issues seem to be mistrust, and perhaps that was one of the reasons why Cpl. Desmond wasn't taking the medication that was suggested for him and that breaking down some of those barriers culturally and geographically even, might be of assistance. Would you have a view on that?

A. I cannot answer that, no.

Q. All right.

A. Sorry.

Q. That's fine, Doctor. Those are all the questions I had for you. Thank you, Dr. Ouellette.

A. Thank you.

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

CROSS-EXAMINATION BY MS. MILLER

(16:17)

MS. MILLER: Good afternoon, Dr. Ouellette.

A. Hello.

Q. My name is Tara Miller and I'm counsel representing the personal representative of the late Brenda Desmond. That was Cpl. Desmond's mother. And I also share representation with respect to Aaliyah Desmond, Cpl. Desmond's daughter.

A. Mm-hmm.

Q. I just want to make sure I've understood some components of your evidence. As I heard you speak through this morning and this afternoon, Ste. Anne's has three different components. The first would be an outpatient clinic? Is that correct?

A. Mm-hmm.

Q. The second is a stabili- ...

A. Yes.

Q. The second is a stabilization unit? Correct?

A. Yes.

Q. The third is the residential treatment component.

Correct?

A. Yes.

Q. And your involvement ...

A. Correct.

Q. ... with Ste. Anne's is limited to the outpatient clinic and the stabilization clinic. Correct?

A. Yes, correct.

Q. And I think you said you see about 110 patients a year in the outpatient clinic?

A. Well, not a year, but three or four times a year, I have to see my 110 patients.

Q. Okay.

A. I have to ... yeah.

Q. And where do those patients come from? Are they former patients of the residential?

A. They are veterans.

Q. Yes.

A. They are veterans patients liberated from the army, and mostly, most of them are suffering from PTSD or work-related mental illnesses. And then we also have RCMP members. There is a contract between CF and RCMP, so we see both of them for the same reasons.

Q. Okay. And I'm assuming, given they're outpatients, are those former military members and RCMP members that live in the area, like, that live in Quebec, or do they travel from other regions?

A. Yes.

Q. They live in Quebec.

A. Yes. They live in the area. For example, us in Ste. Anne, we see the south shore of Montreal, we see Montreal, we see the west island, and the other OTSSC see other parts of the clientele.

(16:20)

Q. Thank you.

A. Yes.

Q. So when you ... I'm going to move into the stabilization role that you play. I think you said you see about 25 to 35 patients there a year, did I get that correct?

A. It is just ...

Q. Approximation?

A. I would have to verify because I never saw the statistics, but usually, there's one per week, but sometimes, if there are too many patients, I can wait two or three weeks before seeing a new one.

Q. Okay.

A. Yeah.

Q. And as you indicated earlier, you said there were two roles or two goals, roles, at the stabilization program and one was to help those individuals reach stabilization, and then the second goal was to make sure they were fit for the residential treatment program. Correct?

A. Yes, correct.

Q. Is it fair to say that there's a third goal of yours as well? When you meet somebody initially, is it not that you are wanting to ensure that the admitting diagnosis is correct and to see if there's anything else that the person needs to be diagnosed with? Is that correct?

A. Yes. Well, my role in the stabilization process is this. You see the patient that comes to us are patient that have been treated many years ago and for many years and for many months, and they need to contin- ... in the stabilization and then they still have big problems. They still need more investigations. So they are sent to us at the stabilization because there they are going to stay for a few weeks and we will have the opportunity to observe them, to see them almost every day for the personnel, for example, and to make a better and

more accurate diagnosis.

Q. Okay, thank you.

A. We can ... when we see someone a whole day, we see much more than in a few hours.

Q. Fair enough.

A. So we can make observations and then sometimes it helps us a lot because we discover things, you know? We discover that some patients don't take their medication so well.

Q. So I appreciate what you're saying is that part of what you do when you see someone initially for stabilizations, you have to do a complete assessment to make sure you have an accurate picture of the diagnosis.

A. Yes.

Q. So I want to move us now into ... again, I want to make sure I understood your evidence and look at some of the documents. So just to help orient you, this is Exhibit 254 and the first page I'm going to ask you to look at ...

A. Yes.

Q. ... is page 46.

A. Okay, I'll look at this.

Q. Okay. So yeah, let me just ask you a few questions just to help orient. So my understanding is that you saw Lionel

Desmond - Cpl. Desmond - five times over the course of his time in the stabilization unit. Is that correct?

A. Yes.

Q. Okay. And if I look at page 46, these look to be chart notes and I see handwriting and it looks like sometimes it's your handwriting, because I see "Robert Ouellette". Would that be fair?

A. Yes, this is my handwriting, yes.

Q. Okay. So the first ... is it fair to say the first time you saw him, of course, was May the 31st, 2016?

A. Yes.

Q. Okay. And then we see that ...

A. Well ...

Q. Sorry, I don't want to cut you off.

A. Okay.

Q. Was that the first time that you saw ...

A. What ...

Q. ... Cpl. Desmond on May the 31st?

A. Yes, 31st, it was the first time.

Q. Okay. And that's when you did your assessment and were able to come up with the diagnoses and did a thorough report which is typed up, and we've seen that.

A. Yes, we've seen that there.

Q. Okay.

A. Yes.

Q. Then the next chart entry I see is June 7th, 2016, it's a short entry and it has your name. It's in French and I wish I had a better command. I wish I had your command of the French language. What does that say?

A. It says: The patient has been ... has had a second visit. "Revu" means "seen again". The case was discussed probably with the team because every Tuesday, we'd discuss, the team. And the note was dictated.

Q. And so was that ... did you see Cpl. Desmond on that date or did you review the file with the interdisciplinary team?

A. Well, we always discuss about the patient on Tuesday afternoon. It's always done. And I don't know. Probably the patient has been viewed on this occasion, yes.

Q. In your review of the file for your evidence today, Dr. Ouellette, have you seen a chart note that was, or a note, that was dictated with respect to your June 7th visit?

A. I have one for the 31st and then the next one is the 14th of June. I don't have one for the 7th of June.

Q. Okay.

A. Yes.

Q. All right. I'm going to move to June the 14th. We see a chart note for June the 14th at page 50 of that same exhibit.

A. Yes.

Q. And that's your handwriting. That's a short chart note. Can you just translate that for us?

A. The meeting was done. The note was dictated. Topamax, which is a medication, was added to the medication.

Q. Okay.

A. Yes.

Q. And then I'm going to get you to look at page 48 of the same document. This is a ... looks like a dictated ... it says, "Case History Sheet". Do you have that in ...

A. Yes.

Q. ... front of you, Dr. Ouellette? Yeah. It's in French, but ...

A. Yes, I have ...

Q. Yeah.

A. I have it here, yes.

Q. If we look at the paragraph just about "Diagnostics".

A. Yes.

Q. This is your review, I think, of how Cpl. Desmond was presenting.

A. Okay.

Q. And my question for you at this point, I interpret, or we understand, there's a sentence towards the very bottom: "Le control emotional est bon." Do you see that?

A. Okay. Yes, I see that.

Q. Okay. So at that point, can you explain to us what you were meaning when you said, Emotional control is good?

A. Well, it means that he is in control of his emotions and he is not agitated. He can express himself in words and he has a good control of his emotions.

Q. Okay. So he wasn't deregulating at that point, his emotions, he was able to ...

A. No.

Q. ... to be in control of his emotions. Okay. And the Topamax ...

A. Yes.

Q. The Topamax is the medication you had told us earlier that you were recommending he take for mood stabilizing?

A. Yes. The Topamax which I gave him at 25 milligrams only, as usually we begin with 50 milligrams and we go up, but

in his case, I did give him such a low dosage so he would be comfortable with this. So that's where I tried to give him more medication, Topamax, yes.

(16:30)

Q. Right. And we heard from you earlier that your efforts to prescribe this mood stabilizer were not met well. And if I can just take you again back to page 50, these are your handwritten notes.

A. Yes.

Q. My recall of your evidence is that there was a nurse who had ... you had looked at the nurse charting notes and she had expressed that Cpl. Desmond was not going to take this medication, and then that led, if I can summarize ...

A. No.

Q. ... that led to a conversation you had with him which I assume is on June the 16th?

A. Yes, June the 16th, effectively. Then ...

Q. Okay. And this is a detailed note that we see at page 50, but it's all in French, so I'm not going to ask you to go through it for us now, Dr. Ouellette.

A. Okay.

Q. But we'll make a request through your counsel for a

transcription of that into English.

A. Okay.

Q. To make sure we've captured it. But as I understand, after June the 16th, that's when you had concerns about Lionel Desmond's resistance to medication changes. Is that fair to say?

A. Yes, that's fair.

Q. Okay.

A. What happened is I prescribed Topamax on the 14th. He didn't want to take it. And then on the 16th, I went to see him and to know what was happening and then talk about the medication. And that's when I saw he had such ... he was such an "interdiction", he didn't want at all to take medication, to talk about medication, and he had this reaction.

Q. That you described earlier about not wanting to ...

A. Yes.

Q. ... take the Desmond out of him.

A. Like a dissociative state, yes. And that's ...

Q. When you say, "Like a dissociative state", can you elaborate on that?

A. Well, it's when he was really mad at me and he didn't want to talk about medication. And then he said, "Don't take

the Desmond, the beast, out of me." He was really mad. So he was, like, dissociated. That's why I say that.

Q. Okay. And that's a clinical term ...

A. It was ...

Q. ... "dissociated", right?

A. Dissociated, yes, it's ... when we talk, for example, about a flashback, flashback is a dissociation. The military, he finds he's brought back in his mission when he was in Afghanistan. He's not there anymore. It really is the trauma. So that's what happened to him because he ...

Q. And that's from your expert opinion ...

A. Yes.

Q. ... Dr. Ouellette, that that day when he said he didn't want to take that medication, he didn't want to "take the Desmond out of me", he was dissociating when he said that, when you had that conversation with him?

A. Yes, he was, yes.

Q. Okay. So that wasn't a flashback, that was ... a flashback can be a dissociative episode, but this, what you're just describing ...

A. Yes.

Q. ... is separate from a flashback.

A. Those are two terms saying the same thing.

Q. Okay.

A. Flashback and dissociation, okay?

Q. All right. I'm going to move off of June the 16th. As I understood your evidence, you did have concerns at that point, given his resistance to the medication and some anger issues.

A. Yes.

Q. You had concerns about whether or not he'd even be appropriate for admission into the residential program. Correct?

A. Yes.

Q. Yes.

A. Yes, correct.

Q. And then according to the notes, which I'm going to be referencing page 52 of that same exhibit - Exhibit 254 - this is the next note in your chart and it says, "June 23rd, 2016".

A. Yes.

Q. We understand from your earlier evidence that on that date, you met with Lionel Desmond, and based on that conversation, you had confidence in him and his ability to participate in the residential program. Is that correct?

A. Well, I talked with Dr. Isabelle Gagnon and with Julie Beauchesne about the fact that I wasn't sure that Lionel Desmond could do the residential program after what happened the day before. So we decided that we would encounter him, the three of us, and evaluate the possibility of Mr. Desmond to go to residential or to go back home. And this meeting with him was rather good because he was calm and he was not angry anymore, and he was anxious, and he was expressing his ambivalence to stay or to go home. And finally, he said that his family was going to see him, coming to see him, in Montreal, and he was rather motivated to stay with us.

So we waited for the weekend to end. We could see that everything went well with his wife and family and it was decided that he would stay with us at the residential program without raising the medication. He would stay with us because he had some improvement in his sleep, in his relation with others, in his interest. He was very much less depressed. So we decided he would stay.

Q. Okay.

A. And he agreed with that.

Q. And then you also, I think, said you had the social worker, Kama Hamilton, have a conversation with Mrs. Desmond.

A. Yes.

Q. And we have her report. It's Exhibit 255. And it looks like she spoke with Mrs. Desmond on June the 28th and ...

A. Yes.

EXHIBIT P-000255 - SUPPLEMENTAL DOCUMENTS - STE. ANNE'S HOSPITAL MEDICAL RECORDS

Q. Would she have shared that information with you following her phone call, Dr. Ouellette?

A. Yes. Yes, she did that at the meeting. Every Tuesday, we have a meeting with the team. Everybody is there. And then Mrs. Hamilton told us about her conversation with Mrs. Desmond and she told her the conclusions that she came to with her. And you have a list of their conversation here on this thing here.

Q. When ...

A. And we realized that, for example, Mrs. Desmond was not afraid of Mr. Desmond, even if her little girl was upset with his change of humour. She said here: "Also to note that her daughter is frightened when he yells but that he has never been physically violent toward them, either of them, and she has never felt that he would hurt them." So there was no physical violence in the family.

DR. ROBERT OUELLETTE, Cross-Examination by Ms. Miller

Q. When you earlier gave your evidence about assessing the appropriateness of somebody for the residential facility and you said, understandably, the people that are there have PTSD and so you want to make sure that you're not introducing somebody into the environment who is going to be disruptive and enhance or increase their stress, there are two things I want to ask you about in this report, as noted by the social worker, and they both deal with anger. That would be one of the things you were worried about, anger outbursts ...

A. Yes.

Q. ... in the residential program. And they're on page one, points one and two. The first is anger issues. "Many triggers. Don't know what they are. Therefore, unpredictable angry episodes. Impossible not to trigger him. Unpredictable. Won't let daughter stay alone with him. For example ..."

THE COURT: Ms. Miller, you get ahead of the document sometimes and ...

MS. MILLER: Sorry.

THE COURT: ... you read it more quickly than we can get it up there and let Dr. Ouellette have a read of it.

(16:40)

MS. MILLER: Thank you. Dr. Ouellette ...

THE COURT: And me. Thank you.

MS. MILLER: Sorry. More ... equally important.

THE COURT: Thank you.

MS. MILLER: Dr. Ouellette, I'm looking at page one of Exhibit 255 and it's up on the screen. And there's points one and two that I wanted to ...

A. Yes, I ...

Q. ... orient you with, yeah. So the first ...

A. Okay.

Q. First point deals with anger issues and triggers and unpredictability. It says: "Example - when daughter hit the car with the four-wheeler, she was afraid to tell him but he was not angry. He said it's okay, as long as she wasn't hurt. But when she spilled water on the floor, he flew into quick escalation, a rage, hollering, yelling."

And then the second point is, "Anger, violence. Two incidences of violence against objects. Throwing drawers around his room."

A. Yes.

Q. "They don't know why he went to work and came back in a different mood." And then the second incident is redacted from the document that I have but I would assume you would've

had the original.

Was there anything about what you read or what Ms. Hamilton reported to you about these anger issues, the triggers and the violence, that caused you concern or impacted your ... We know he was admitted, but did this cause concern for you?

A. Yes. I read ... already, I've read all this report many times and the number one there ... Well, it's not me who has done this assessment but I think that Mrs. Hamilton would be the best one to comment on her report. But number one, when I read this, I know that people presenting PTSD can be like that - unpredictable - and it depends on the ... what they feel inside. For example, she says: "When she spilled water on the floor, he flew a rage." Probably because he has personality issues, obsessive-compulsive traits. But it is difficult for me to interpret that because I'm not the one who did the interview and ...

Q. I appreciate that, Dr. Ouellette, but my understanding from your evidence was that you were making ... part of your role in the stabilization clinic was to make an assessment as to whether somebody was appropriate to move into the residential treatment program and ...

A. Yes.

Q. ... part of that assessment involved you assessing whether or not that was going to perhaps be disruptive for the other patients and anger was something you were worried about. So that is what I was orienting you to. You had the social worker reach out to Mrs. Desmond to gather this information. You advised she shared it with you. Did that impact your decision at all or cause you to reflect on the appropriateness of Cpl. Desmond's admission?

A. This did not change my opinion. It was something that we see in patients that we hospitalize in the residential ward. It can be seen many times and there is a reason for that. We call that "emotional dysregulation". The problem is people don't know why it happens. Seeing that, I could see that he wasn't angry with his little girl because she did something to the car, but he was angry at her because she spilled water on the floor because he is an obsessive-compulsive and he wants everything to be clean, to be well-arranged. So it is probably because of that. There is an explanation for that.

Q. Right.

A. But people don't know that.

Q. The explanation ...

A. And ...

Q. If I can put it this way, Dr. Ouellette, the explanation for this behaviour was grounded in his mental health diagnoses. Correct?

A. Yes, yes.

Q. Okay, thank you.

A. Well said, yes.

Q. Thank you. This wasn't something he had necessarily purposely done. It was a result ...

A. No.

Q. ... of, and a symptom of, his underlying mental health diagnoses. Correct?

A. Anxiety, and his reaction was difficult to understand, but there was a reaction and it was not violence.

Q. Right. But there are some violence ... anger issues noted.

A. The second ... yes. And it's a little more concerning because if someone yells and say things, it's verbal, but if he moves objects, then it's a step farther, okay? And this was a little more annoying. But while he stayed with us, we didn't see that.

Q. Okay. But is it fair to say that the verbal outbursts, and even moving ... the physical anger outbursts,

that, from your expert opinion, those were again manifestations, behavioural manifestations, of the underlying mental health diagnoses?

A. Yes, yeah.

Q. Okay, thank you.

A. Yes.

Q. I want to ask you just a ...

A. Difficulty to control ...

Q. Go ahead.

A. Yes. He has difficulty to control his anger, yes.

Q. As a result of his mental health diagnoses, yes.

A. Yes.

Q. I have one small question before I move into my last topic, but you mentioned to, I think, my friend, Mr. Macdonald, or Mr. Rodgers, you said under the residential program, there's actually one day where spouses can come in for the day and participate and ask questions and observe. Now I understand you don't have any role in the residential program, but is that ... do you have any idea why Mrs. Desmond didn't participate in that one day at the residential program?

A. I don't know if she did or not, but I know something, that some people stay far away and have obligations and they

cannot come. Sometimes they have children at home, they have work, so we have to arrange a meeting. Sometimes I think they do that in the weekend. So you would have to ask Kama Hamilton about that.

Q. Okay.

A. She is the one to know. But usually, people want to come. I don't know if she met, effectively, Mrs. Desmond.

Q. Okay. We know your evidence is, and we know that, she was there the weekend before, physically, in Montreal.

A. Yes, yes.

Q. And then Ms. Hamilton talks to her on the 20th. We'll ask her those questions. I appreciate, Dr. Ouellette, your position on that.

A. Okay.

Q. I want to move now to your actual diagnosis of mixed personality traits, including paranoid traits. That was the diagnosis that you provided.

A. Yes. Paranoid ...

Q. One of four.

A. ... obsessive-compulsive, and I ... those two, yes, those two.

Q. You may not know this, but that diagnosis, the first

time we have seen that is in your report of May 31st, 2016.

A. Mm-hmm.

Q. You touched on this earlier. At the end of anyone's stay at the residential facility, there's a discharge report and we know that that was authored in August and forwarded to various people in October. My friend asked you about the absence of any section from you, as the psychiatrist.

A. Mm-hmm.

Q. When I read through that report, I don't see any mention of the diagnosis of personality trait disorder. Is that fair to say, Dr. Ouellette?

A. Mm-hmm.

Q. That's an accurate characterization?

A. At the end of what?

Q. When I read ...

A. Of the hospitalization?

Q. The residential ...

A. At the end?

Q. At the end of the residential program, the discharge ...

A. Yes.

Q. ... report?

A. You didn't see?

Q. Yes. There's no reference to your diagnosis of personality ...

A. No.

Q. ... mixed personality traits.

A. I don't know what happens to the report after the hospitalization ends. Usually, when a patient is leaving the hospital, there is a summary of the hospitalization with a diagnosis.

(16:50)

Q. Right.

A. Usually. I have it here. I don't know if it's given to the patient.

Q. Okay. Do you know if Cpl. Desmond was ever told that he had mixed personality trait disor- ... or not a disorder, but he had a diagnosis of mixed personality traits? Would you have had that conversation with him?

A. Not this way, but patients ... ordinarily, patients have ... are very sensitive when we begin to talk about personality problems.

Q. Right.

A. If you look at the first time I saw him, the first

evaluation I made on the 31st of May.

Q. Yes.

A. And then if you look at page four under "Examen Mental"...

Q. Yes. And so that's page 44.

A. Mental status.

Q. For our reference, that's page 44 of our exhibit, yes.

A. Ahh, okay for you.

Q. Yeah.

A. Okay. Then in the middle of this paragraph, I say: "Monsieur declare ..." Do you see it? "Monsieur declare avoir de la difficulte a faire confiance aux autres." The "traduction" of that is: "Mr. Desmond say he has difficulty to trust others."

Q. Yes.

A. Okay? So this is a soft way to say, "Mr. Desmond has paranoid traits." Okay?

Q. Yes.

A. Because someone with paranoia has difficulty to trust others.

Q. Fair enough.

A. That's what I see there, but we have to say it in

another way so the patient will not be shocked by it.

Q. And when you prescribed him the Topamax, which was a mood stabilizer which you indicated was going to help with the personality traits and the dysregulation and the irregularity ...

A. Yes.

Q. ... in mood, would you have explained to him why you were prescribing him that medication, Dr. Ouellette?

A. All the time. Each time we give a medication to a patient, we have to explain him why we give it and what it is going to do and also, sometimes, what are the secondary effects of this medication and what to do if they appear. And every time we do that, it's okay, because if we give a new medication to someone without explaining why, he will call us back. He won't be compliant to that.

Q. Fair enough.

A. Yes.

Q. Would you have prescribed ...

A. It's the same thing for us.

Q. No, fair enough. Would you have ...

A. The same thing for us.

Q. Would you have prescribed the Topamax if you did not

have a diagnosis of mixed personality trait?

A. I might have prescribed it for PTSD because it is a real good medication for PTSD, especially when patients have tried a lot of medication before. Especially antidepressants. And antidepressants, they give secondary effect, and with a patient like Mr. Desmond, afraid of secondary effects, I preferred to give Topamax which was more acceptable and working in the same time with PTSD and in the same time as a mood regulator.

Q. Okay, thank you.

A. So I have both effects with the same medication, yeah.

Q. I want to ask a few questions about the diagnosis of mixed personality traits, Dr. Ouellette. You've said - and I'll just paraphrase your evidence - that, of course, was one of several comorbid conditions that Cpl. Desmond had. He had depression, alcohol dependency, and anxiety. And ...

A. Yes.

Q. ... as I recorded your evidence, you said, "Traits of personality can exist independent of PTSD." Is that fair?

A. Mm-hmm.

Q. Yes.

A. Yes.

Q. But then you went on to say, "But under pressure with PTSD, these traits can be made worse."

A. Yes.

Q. Okay. So is it possible ...

A. Yes, they ...

Q. Is it possible that somebody can effectively be asymptomatic of any personality traits and they become symptomatic as a result of the stress associated with PTSD?

A. No. No. Personality traits are there. They can be seen. It's the signature of the person, you know, like the colour of their hair. It's the way of relating to others and the way of thinking things and resenting things. They are there but they can be quiet, you know, quiet.

Q. Okay.

A. That's okay. They can be a quality too. For example, someone can have obsessive-compulsive traits and it can be a quality because they will clean the kitchen. Everything is going to be well-arranged in the house. They pay their bills. Everything is okay. But if something comes up and they have a great stress, then they will begin cleaning all the time compulsively and it becomes much more than before. So it's not ...

Q. Then it would become more clinical.

A. ... a quality anymore. Yes.

Q. Yes.

A. It becomes worse.

Q. Okay. So from what I've been hearing you say, you believe that Cpl. Desmond had some underlying personality traits that were not clinical.

A. Yes.

Q. Is it fair to say they were not clinical until ...

A. Subclinical, yes.

Q. ... until the trauma of the PTSD and combat in Afghanistan. Is that a fair characterization?

A. Yeah.

Q. Okay, thank you.

A. Yes. Exacerbation of underlying traits.

Q. Yes. And as we touched on earlier, just again, the symptoms of the personality trait were the paranoia, the trust issues, the anger, the irritability. I think you said the doubts about his spouse and the jealousy, those were symptoms of the personality trait disorder. Did I capture that correctly?

A. Yes.

Q. Okay.

A. Yes. I have a definition here of the paranoid personality traits. Do you want to hear it?

Q. Yes.

A. The definition? It says: "A pervasive distrust and suspiciousness of others such as their motives are interpreted as malevolent beginning early adulthood and presenting a variety of context. Suspects others exploiting, harming, deceiving, doubts about loyalty and trustworthiness of friends. No confidence." They make no confidence to anybody because they don't want it to be maliciously against them. Reads: "Even demeaning in the actions of others. Persistent. Bear grudges. Perceived attacks are on reputation, no (appearance?) to others, and recurrent suspicious regarding fidelity of spouse." This is the definition.

Q. Okay, thank you. And ...

A. And that's why ...

Q. Go ahead.

A. Yes.

Q. You were going to say, That's why ...

A. And that's why I gave this diagnosis to Mr. Desmond.

(17:00)

Q. And I think you said in your evidence this morning

with Mr. Russell that that diagnosis actually explained, in hindsight, a lot of the challenges that he had been having.

A. Mm-hmm.

Q. Correct?

A. Yes. And in the suspiciousness he has against medication, against people around.

Q. Yeah. And one issue you talked about earlier was bill payments and how he ... this was, I think, around the ... you were talking about giving permission to talk to his wife, and not, and taking back bills, and not. If I can characterize it this way, Dr. Ouellette, him taking back the control of the paying of the bills or taking back the consent to speak to his wife, that wasn't about exercising power, that was the manifestation of his trust and mistrust as a result of the disorder that you had diagnosed him with. Is that fair to say?

A. Yes, it's fair to say. He was doubting her, doubting her capacity to ... with the finances, and maybe he was doubting that she was taking money from him too. We don't know.

Q. Yeah. But all of that was consistent with the symptoms you would expect and you had seen in him ...

A. Yes.

Q. ... of the mixed personality trait.

Okay, thank you, Dr. Ouellette. I appreciate your time here today. I know it's been lengthy. There may be others with questions for you.

A. Thank you. I hope I threw some light on this case.

Q. Thank you.

THE COURT: Ms. Ward, do you have any questions?

MS. WARD: I do. Thank you, Your Honour.

CROSS-EXAMINATION BY MS. WARD

(17:02)

MS. WARD: Good afternoon, Dr. Ouellette.

A. Hello.

Q. My name is Lori Ward and I represent ...

A. Good afternoon.

Q. ... the Government of Canada. So that includes the Armed Forces and Veterans Affairs, among others. I just have a few questions.

A. Okay.

Q. I won't keep you much longer.

Ste. Anne's is a provincial facility operated by the Province of Quebec. That's correct?

A. Ste. Anne's was owned by, I think it's Veterans

Affairs Canada, or ACC before, and then since a few years, it has been given to the Province of Quebec and integrated in the Regie de l'assurance maladie and in the Douglas Hospital, the west of the Island of Montreal. Now it's under the supervision of Douglas and McGill, yes. But the clinic, the outpatient clinic, is, I think is (French term) by Veterans Affairs Canada, but the budget is (inaudible) by Douglas, I think.

Q. So for a patient or a client like Mr. Desmond, though, Veterans Affairs will be paying the bill, but not directing ...

A. Yes.

Q. ... his care in any way.

A. No. No. Paying the bill, yes, but the administrative part is made by the Douglas Hospital, yes. But I think that the ... all the money spent for that is from Veterans Affairs Canada, yes.

Q. Okay. You spoke earlier about a reluctance in military members to seek treatment for mental health conditions, and I just want to ask you, you know, we know that in recent years, there's been a much more public conversation about mental health, but is it fair to say that that reluctance was not just present in military members but, in fact, in civilians or the general public, there's been a reluctance to talk about mental

health issues and seek treatment?

A. Mm-hmm. Are you talking about military men and women or civilians?

Q. I'm asking if that ...

A. Civilians ...

Q. ... if the reluctance to seek treatment and the perception of shame and that is also present in non-military people?

A. In non-military, yes. I can say that too because, you know, I'm an old psychiatrist. I began working in 1974, and even 1970, and at that time in my private practice, people were coming to see me and they would hide on the floor. They would not know ... want people to know they were coming to see me. And they were civilians. And sometimes they would sit at the door of another doctor, not too far, not to be identified.

In the history of psychiatry, it has been like that since maybe 1970, and in the civilian and in the army too. But this has evolved a lot, and nowadays, the civilian have no problem going to see a psychologist or a psychiatrist. Maybe they fear taking medication. They don't want to take too many medication, but this has evolved, and with the psychoeducation, this is much better. And it is the same thing in the army. When I began

working in the army at Valcartier in 2000, it was the same. The militaries, military men and women, they waited a long time to say that they had something, they were sick, they were anxious. And why? Well, because it has ... it was influencing their work, their promotions, their ability to go back to missions, okay?

So there, too, there were a lot of psychoeducation, people going with them, peer support, and preparation to missions, predeployment, post-deployment, after they would come back, and ... but the fact is, the problem that was ... the real problem that we saw was the fact that if they had PTSD and if they were ... they had to have treatment, they would be put in, not permanent category, medical category, but in ...

Q. Temporary category?

A. ... the contrary.

Q. The temporary category.

A. Yes, they would be put on temporary category for six months and then another six months, and sometimes a third six months. And during this time, the treatment went on and we tried to help them, we tried to help them go back to work. And a lot of things were done then because they wouldn't go back to the same place they were working. We tried to find them some

good jobs, but not too demanding, and then progressively go back to work, go back to the gym and things like that.

So ... but in the long run, the PTSD is something that, it is a very heavy load (physically?) you know. And eventually, they came to be released from the work because they cannot go back to mission. They are not fit for missions.

(17:10)

We tried to talk with the officers in charge, saying that maybe they are not fit to go to missions, but maybe they are fit to be accommodated and to work on the bases. So what happened was they feared to come and seek treatment because they feared to lose their job and to be ... and with, when having a family, it's not ... they fear to be released and not to be able to take care of their family. And in the same time, they had this PTSD.

So it was a big stress for them and I know that there was a lot of things made for them to reassure them and to assure their treatment. For example, the OSI clinics, all the help they could get. The pensions, the ... So yes, it took a long time for them to be reassured and to know that there was something to do, even if they were released. But nowadays, some of them have difficulty. So they come to consult late, very late, and ...

Q. Okay, thank you, Doctor. Switching gears for a

minute. I think there's been some confusion about the length of stay in Ste. Anne. As I understand it, Mr. Desmond was with you in the stabilization phase for about four weeks.

A. Four weeks, yes.

Q. Is that an average time in the stabilization phase?

A. Sometimes it's one week or two. It can be up to eight weeks. It depends on what we have to do. If the patient has to take much more medication, we have to wait to see the effects of the medication, and then if some secondary effects arise, then we have to stop it and come back to another medication. So we lose time then. We have to choose well at first, but sometimes we have to adjust and it can take a longer time. Sometimes eight weeks. But usually, in four weeks, we know exactly what is going to happen, yes.

Q. Okay. And when he moved to the residential treatment phase, it was expected that he might be there about eight weeks?

A. Usually, it's eight weeks. This is something ... almost all of the time, it's eight weeks, sometimes a little more but rarely less, yes.

Q. Okay. So I think that we heard from some witnesses earlier who were under the impression he was expected to be at your facility for six months. Would that be out of the

ordinary?

A. Oh no. No, this is not the case. Never ... never per- ... I've never seen someone staying six months, but I've seen persons coming and have a treatment, hospitalization, and then go back home, and then a year later, coming back from three more months. This can happen, but six months, I never saw that in 20 years.

Q. Okay, thank you.

Earlier, you were asked whether Mr. Desmond had insight into his condition and you talked about a point where he said, I think I have PTSD. But right after that ...

A. Mm-hmm.

Q. ... I think you indicated that he connected that possibly to a head trauma or concussions.

A. Mmm.

Q. Was that how he framed it? Was he thinking of it in terms of, I had head trauma that caused my PTSD?

A. Well, for what I could see, I saw that he was hesitating saying he had PTSD, but when he came to the ward and he discussed with other patients about PTSD, they talked together and everybody has PTSD. So maybe he realized that he might have PTSD himself. That's why maybe he said that. And

... but the insight was really low, you know. For example, he said that he had the head concussions. He was complaining about pain and he wanted to undergo treatment for attention and concentration, you know. The treatment is called ... he was calling about that. Neuroperforma- ... neurofeedback. And neurofeedback is made effectively for person who have cognitive impairment. But in his case, it's him who said that. It was a surprise because he didn't want to seek treatment for PTSD with medication, but he wanted to undergo treatment for neurofeedback for neurocognitive problems. That's why we asked for those tests, and those tests, they are slow to arrive. You know, a neuropsychologist, if you want to take an appointment with a neuropsychologist, it takes ... sometimes it can take two or three months. It's long. And in regions, it's not available easily.

So with those tests, the result of those tests would have told us, was it okay? This treatment or this treatment? What was the cause of the cognitive problems? This was the first step, but him, he was over there with his demons, okay? It was too soon. And that's why I said he didn't have so much an insight about the ... he didn't know exactly what was going on in himself and he was doubting PTSD. He preferred to have

concussions and treatment for that. So it was difficult to have his trust, you know.

Q. Dr. Ouellette ...

A. If you ...

Q. Go ahead.

A. If you go to see someone who is a specialist, for example, in neurology, and he tells you you have this and that and we will do this and that, you have to ask then this person because you know he studied in that. But Mr. Desmond, if you told him, You have PTSD and you have depression and, yeah, he was not sure. He would be saying, No, I had concussions and this I should do. It was difficult to obtain trust from him and insight.

(17:20)

Q. Is it possible that ... you know, this goes back to what you said before about military members not seeking treatment because it's a sign of weakness. I wonder, is it possible that it might be more palatable to a military member to think that their troubles are due to some organic or physical trauma like a head trauma as opposed to a mental illness?

A. Yes, absolutely. And they feel less shame saying that it's something physical than saying that it's something

psychological.

Q. And so it was Mr. Desmond himself who raised the idea of the neurofeedback. And so are you saying that it was because of his ideas about his cognitive deficits that the recommendations were made for the neuropsychological assessments and whatnot?

A. Yes. We wanted to know exactly what was causing the neurocogni- ... the cognitive problems of Mr. Desmond, and the evaluation was very important for us to be able to send him to the right place to be treated. But, you know, depression can cause lack of concentration and attention and affect the memory. PTSD can affect the concentration, and the anxiety with PTSD can affect memory too. And drugs too. Cannabis can affect the concentration and ability ... those things ...

So there were so many things affecting, possibly, the cognitive aspects of Mr. Desmond that ... and the concussions, too, could have done that. So it was important to assess all those aspects.

Q. Okay, because in previous evidence from other witnesses, it doesn't appear that Mr. Desmond ever reported any head trauma and there's no record of him being treated for such head trauma.

A. Yes.

Q. And the first that we heard of the head trauma was from Dr. Murgatroyd and Dr. Njoku at the OSI clinic in New Brunswick.

A. Yes.

Q. So apparently, he reported no history of head trauma or concussions to, say, Dr. Joshi and Dr. Rogers at the OTSSC.

A. Yeah.

Q. And so I'm thinking, I mean you said earlier that the neuropsychological assessment could rule out any physical causes for his cognitive deficits and that it was important to do so but ...

A. Yes.

Q. So as you've said, any cognitive impairments could very well have just been from his PTSD or depression.

A. Yes indeed. And also, I saw that Dr. Isabelle Gagnon did a lot of tests with him to rule out this and I think that he could not have done ... Well, you see, I know that a military man or woman in mission, when they have concussions or are hurt, there are hospitals and doctors to see them. If it could have been something really bad, they would have ... do something for that. Radiography or ... No. And he went on working from 2007

to 2015 in the army, so if it was something very severe, he would not have been able to work with that.

Q. Thank you, Dr. Ouellette, those are my questions.

A. This is my opinion. Okay.

Q. Thank you.

THE COURT: Mr. MacKenzie?

MR. MACKENZIE: No questions, Your Honour.

THE COURT: Thank you. Ms. MacGregor?

MS. MACGREGOR: Yes, Your Honour, just a few.

CROSS-EXAMINATION BY MS. MACGREGOR

(17:25)

MS. MACGREGOR: Good afternoon, Dr. Ouellette.

A. Good afternoon.

Q. I only have a few questions for you, so we won't keep you very much longer.

Dr. Ouellette, we've heard a lot today about the meaning of stabilization and you've been asked questions about, you know, what percentage Mr. Desmond had stabilized before moving on to the residential phase. And I just want to confirm, when we talk about stabilization, we're not talking about, you know, being fully treated at that point, are you.

A. No, absolutely not. Nobody that comes to us are fully stabilized. It would be ... we would be really good doing that, but no. Partially stabilized and then able to go on with the treatment in residential. We assume that if they can do that, if they are stabilized, partially, they can do the residential program and then they will go on stabilizing.

Q. And so even though you had expressed some concerns early on in the program, by the time that he ultimately moved on to the residential phase, you felt he had sufficient stabilization to move on to that phase of the program.

A. Yes.

Q. And I think your evidence ...

A. Yes.

Q. ... was because he had made improvements in sleep, decreased anxiety, his depression had decreased as well, improvement in nightmares. Is that right?

A. That's right. And it was a surprise that the depression would go so fast with him, you see, because when he arrived, he had no interest in nothing, and then suddenly began going bicycling, he began to play the guitar, he began to eat well, to have friends, to play pool. So he was really better on the subject of depression, yes.

Q. And as part of your ongoing assessments throughout the stabilization phase, you did assessments to, I guess, assess his level of suicidal or homicidal ideation and you didn't find any indication of either of those, did you.

A. No.

Q. Thank you.

A. I didn't find problems with that, no.

Q. Thank you.

A. And you can understand, excuse me ...

Q. It's okay. Go ahead.

A. ... but every day, the nurses in the programs, stabilization or residential, every day they inquire the patients about are they ... they're ... are they suicidal or homicidal. This is all the time. There's a screening for that, yes.

Q. Okay. Thank you, Dr. Ouellette, those are my questions.

A. And nothing happens. Thank you very much. Thank you. It's been a long day.

THE COURT: Dr. Ouellette, I canvassed the room. No one has any additional questions for you. I can tell you that unless ... I'm sorry I ... you know, I occasionally speak out of

order here because I see when I made that comment, that Mr. Russell started to stir in his seat in a very uncomfortable way, which suggests to me that he may have a follow-up question for you. Mr. Russell, did I interpret your body language correctly?

MR. RUSSELL: You did, Your Honour, and I certainly won't push my luck, given the hour.

THE COURT: No. If you have a question, we have Dr. Ouellette. He's been very patient and I'll give you an opportunity to ask your final questions. Thank you.

A. Okay.

RE-DIRECT EXAMINATION

(17:30)

MR. RUSSELL: Yes, Doctor, and I apologize. It's late in the day, so I'll be very brief. I just have ...

A. That's okay.

Q. ... a point of sort of clarification, just so I get your evidence right.

So as we understand your testimony today, you had evidence and were of the opinion that Lionel Desmond was paranoid, distrusting, and a jealous husband at times.

(17:30)

A. Yes. The word "paranoid" ... I would say Lionel Desmond had paranoid traits. Being paranoid means other things, but he had paranoid traits and jealous at some point. And the second part of your affirmation, I don't remember.

Q. Distrusting.

A. This ... yes, this is right.

Q. So my question is this. Am I understanding your evidence properly that his diagnosis of PTSD, although it certainly didn't help, it didn't cause him to be paranoid traits, distrusting, or a jealous husband?

A. No, not the diagnosis of PTSD, but this diagnosis of PTSD might have exacerbated his trait of personality.

Q. Okay.

A. Every ...

Q. Nothing further, Your Honour, I just wanted to clarify it.

THE COURT: So before I thank the Doctor, anyone else have a question they've forgotten? Pass? No. All right.

Dr. Ouellette, I know that you have spent time with counsel preparing for your evidence today and I know it's taken a lot of time, and I know that you appreciate how important it is for us to have good insight into your time with Cpl. Desmond in his

time at Ste. Anne's. It really allows us to have, I think, a better and a fuller appreciation for some of the complexities that were presented to you and how Cpl. Desmond presented there as well. Again, your information has been very valuable to us and I would like to thank you for your time, as I think all the others would as well. So thank you again, Dr. Ouellette. Have a good day. Stay safe. Thank you.

A. Thank you very much, Your Honour, and have a good day too. And I want to tell you that I consider this Inquiry to be a part of our work to understand what happens to the patients that we see and to help others understand too what might have happened. And we're sorry it happened. Very sorry.

THE COURT: All right. Thank you very much, Dr. Ouellette. I don't see that we'll have a particular need to come back and ask you any further questions, but there's always that possibility we may speak to you again. Thank you.

A. Thank you very much.

WITNESS WITHDREW (17:34 HRS)

Q. All right, thank you. We'll adjourn for the day, Counsel, thank you.

COURT CLOSED (17:34 HRS)

CERTIFICATE OF COURT TRANSCRIBER

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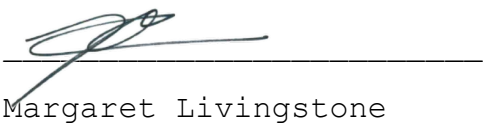

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