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 9, 2021

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DR. RANJINI MAHENDRARAJAH

NATASHA TOFFLEMIRE

EXHIBIT LIST

MARCH 9, 2021

COURT OPENED (09:30 HRS.)

THE COURT: Thank you. Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Thank you. Mr. Murray, I see the podium is in front of you this morning.

MR. MURRAY: Yes, Your Honour.

THE COURT: Do you have a witness for us?

MR. MURRAY: I think so. Dr. Ranjini Mahendrarajah.

THE COURT: Good morning.

DR. MAHENDRARAJAH: Good morning, Your Honour.

DR. RANJINI MAHENDRARAJAH, sworn, testified:

THE COURT: Have a seat, please.

So, Doctor, just a couple of things before we begin. There's a fresh bottle of water there for you. And in this particular room, I will permit ... As you can see counsel when they come in and out of the room will always wear their masks. If they move from their assigned places they also wear their masks, as I do. If you wish to remove your mask to testify you are certainly permitted to do that in this particular venue.

A. Thank you, Your Honour.

THE COURT: Thank you. Mr. Murray?

DIRECT EXAMINATION

MR. MURRAY: Thank you. Dr. Mahendrarajah, good morning.

A. Good morning, sir.

Q. How are you today?

A. Good, thank you, sir.

Q. All right. I'm going to get you to tell the Inquiry your full name.

A. Okay. My name is Ranjini Mahendrarajah.

Q. Okay. Now, Dr. Mahendrarajah, I understand that sometimes people use your first name and they say ...

A. Yes.

Q. ... Dr. Ranjini.

A. Yes.

Q. Okay. Are you comfortable if I use that?

A. Yes, yes.

Q. Okay. In fact, that may be more the custom down here than the exception, is it?

A. Yes. Yeah, I don't mind calling my name.

Q. Okay. All right. I see in some of the notes we see "Dr. Ranjini", so I'll go with that if you're comfortable with that.

A. Yes, please.

Q. Dr. Ranjini, you have some materials with you, are those some medical records?

A. Yes.

Q. We're going to have some medical records that will be on the screen there as well when we get to them. So you can either use paper copies or the screen, whatever you feel more comfortable with.

THE COURT: I take it that Dr. Ranjinii has a copy of

the medical records that we have and that would be up on the display at any rate?

MR. MURRAY: I believe so, yes, Your Honour.

THE COURT: And is her copy numbered the same as ours, do you know?

MR. MURRAY: I'm not sure about that but ...

THE COURT: All right.

MR. MURRAY: ... we have a couple of specific pages we're going to be looking at so I don't think it's going to be an issue.

THE COURT: All right. Thank you.

MR. MURRAY: So, Dr. Ranjini, first of all can you tell us how you're employed? Where do you work?

A. I'm working in Guysborough. I work in the ... I work as a family doctor and also I cover the ER (inaudible - audio), and also I look after the Milford Haven Nursing Home patients.

Q. Okay. And I think you provided us with a copy of your *CV* or your resume which outlines your training and your work history.

A. Yes.

Q. And I think we've marked that as Exhibit 257.

A. Yes.

Q. And Exhibit 257, it's on the screen now, is that your *CV*?

A. Yes, please. Yes.

EXHIBIT P-000257 - *CURRICULUM VITAE* OF DR. R. MAHENDRARAJAH

Q. Okay. So I'm going to ask you a few questions just about your training and your work history that leads up to working in Guysborough today.

A. Yes.

Q. So you received your medical degree in 1998, did you?

A. Yes.

Q. And that was at the University of Jaffna in Sri Lanka?

A. Yes.

Q. Okay. And the degree specifically is a MBBS, that's a medical degree is it?

A. Yes.

Q. Okay. And, Dr. Ranjini, after working for a short period of time in Sri Lanka you relocated to Canada, did you?

A. I worked little bit time, almost 10 ... 12 years.

Q. 12 years before you came to Canada?

A. Yes.

Q. I see, okay. And when did you relocate to Canada?

A. I came twice. The first time I came in 1999 ...

Q. I see.

A. ... I did do some exams and then I go back then came back in 2002 and then I stayed permanently here.

Q. I see. In 2002 you came and stayed?

A. Yeah.

Q. Okay. And initially when you came to Canada where did you work?

A. I didn't work anywhere.

Q. Okay.

A. I do my exams.

Q. Right. And that takes a period of time, does it, to become licensed in Canada?

A. Yeah.

Q. And when you did start to practice, was it in Guysborough?

A. I did get some emergency medicine training in Cape Breton Regional Hospital ...

Q. Yes.

A. ... then I started working in Guysborough since January 2005.

Q. 2005. And you've stayed ever since have you?

A. Yes.

Q. 16 years now in Guysborough?

A. Kind of.

Q. Yes. You must like it?

A. Yeah, I love it.

Q. Good. So the nature of your practice in Guysborough, you said you were a family physician are you?

A. Yes.

Q. Okay. So can you give us a little bit of a description of the nature of your practice? I assume it's a very general medical practice, is it?

A. Yes. I go to the hospital first and we do the rounds, in-patients, then we finish our rounds then I go to the office and see my office patients, and in between sometimes we are on-call for emergency department. If they call in, we go and see the patients, and otherwise we do our regular medical clinic. And also, if the nursing home call me to see the patients, I will go and see them too.

Q. Okay. Where is your clinic located in relation to the hospital?

A. It is in the basement of the hospital now.

Q. Okay. And how many physicians are there in Guysborough?

A. Right now myself and Dr. Bell.

Q. Sorry, the other doctor's name?

A. Dr. Bell.

Q. Dr. Bell, okay. Is there normally two or are there ...

A. Usually ...

Q. ... have there been more?

A. ... we were four and then come down to two. And Dr. Bell is going to go on retirement, so I don't know.

Q. I assume you're hoping to attract other physicians?

A. Somebody we'll get in, yes.

Q. Okay. So you said initially you will do rounds in the hospital?

A. Yes.

Q. Any sense of how many people, how many patients you might see in the Guysborough hospital?

A. We have ten beds. Most of the time we are busy there so we see them. Whoever admit the patient go for first go for round and whoever admit the patient they are responsible for that person.

Q. Okay. So if you admitted, for example, five of the patients you would be responsible for those five ...

A. Yes.

Q. ... Dr. Bell for the other five, for example?

A. Yeah.

Q. Okay.

A. Yes.

Q. And you say typically you're busy. So are most of the beds used?

A. Yes. Most of the time we are busy.

Q. Okay. And at the hospital in Guysborough, what ... I assume there are certain types of things that you can deal with there and other patients go to St. Martha's or elsewhere?

A. Yeah. We do people who we could able to look after. If somebody beyond our capacity/expertise we will help ... get the help from St. Martha's, then we transfer them.

Q. Okay. And you make that decision, what you can ...

A. Yes, the presentation.

Q. Okay.

A. And we start the early treatment, whatever we could ... able to provide. Like, for say, if somebody come with acute MI we do the basic investigations, history, and then start the treatment then we transfer them to St. Martha's ...

Q. The example ...

A. ... after stabilizing the patient.

Q. The example you just gave "acute MI", so a heart condition?

A. Yes, cardiac consult.

Q. Right.

A. Myocardial infarction.

Q. Okay. Are there other types of conditions that you might not deal with in Guysborough that would more appropriately go to St. Martha's?

(09:40)

A. We have trauma patients, patients come see ... do the basic assessment and we may need to send them to New Glasgow for we ... where we have orthopaedic access, so we do that. And surgical patients come, so we do surgical candidate to St. Martha's. And if somebody come in a mental health crisis and they are really having suicidal thoughts, then we always call the psychiatrist on call and send them.

Q. Okay. And I was going to ask you about that. If somebody presents with mental health difficulties, you said if they're acute you would either send them to St. Martha's or consult with a psychiatrist?

A. Yes.

Q. So what types of mental health difficulties would be acute that would require that?

A. Somebody really suicidal, we always send them to St. Martha's, and really agitated we couldn't able to handle or psychosis kind of, acute psychosis, we call the psychiatrist on call and transfer the patient.

Q. Okay. How would they be transferred to St. Martha's if they were in acute mental health distress?

A. We always call EHS and send them by EHS ambulance.

Q. By ambulance, okay. And you say there's always a psychiatrist on call.

A. For 24/7.

Q. Okay. And those are psychiatrists in Antigonish, are they?

A. Yes.

Q. So there isn't a psychiatrist in Guysborough?

A. We don't have any psychi- ... no specialist in our hospital.

Q. Okay. And we've heard from ... in our earlier session, from the psychiatrists, some of them, Drs. Slayter and Rahman, in this proceeding. Who would you typically consult? Would it be Dr. Slayter or Dr. Rahman or would there be others?

A. Whoever on-call doctor we call and they accept the patient and then we send the patient there.

Q. Okay. Now you said that you have your patients in the hospital and then you see patients in the clinic as well?

A. Yes.

Q. Okay. And your clinic, it's the Guysborough Medical Clinic and you have the Anita Foley Health Services Centre, is that ...

A. Yes. Yes.

Q. ... two names for the same clinic?

A. Yes. Yes.

Q. Okay. So the clinic was named after Dr. Foley at some was it?

A. Yes.

Q. And she used to practice in Guysborough before she passed away?

A. Yeah, she was working for more than 40 ... 45 years.

Q. Right.

A. Yes.

Q. Okay. Now in the clinic I assume you have a large number of patients that you see there?

A. Yeah, we have. Yes.

Q. Any sense of how many patients overall the clinic sees?

A. The Guysborough County people are mostly our patients, so I couldn't tell how many.

Q. Sorry, I just lost you there.

A. I couldn't tell you how many people living in Guysborough exactly, so ...

Q. Right.

A. Sorry.

Q. That's okay. But all of the people in Guysborough are your patients for the most part?

A. Not mine, our practice.

Q. The clinic, yes.

A. Most of them, only a few go to different doctors for long time so ...

Q. So basically most of the families in Guysborough you would see them or see some members of their family, their relatives, that type of thing?

A. Yes.

Q. Okay. And it's been that way, has it, since you started in 2005?

A. Yes.

Q. Okay. So you build up a bit of a history, I guess, do you with certain families? You get to know them ...

A. Yes.

Q. ... and different generations of the same family?

A. Yes.

Q. Okay. And you say you also do some work at the Milford Haven Nursing Home which is also in Guysborough County?

A. Yes. It is attached to the hospital.

Q. It is? Okay. And how often do you go to the nursing home?

A. Every Wednesday I do the regular rounds, then I go ... they call me. So most of the time I go almost daily kind of because I need to see the bloodwork report or ... I call them from my office nowadays so ...

Q. Okay. So given that there's only two doctors right now in Guysborough you're probably fairly busy are you?

A. We are busy, yes.

Q. And how often would you be seeing patients in the clinic? How many days a week?

A. I work four days a week and I ... yeah, four days a week.

Q. Okay. And do you see patients in the clinic? Once

you're done with your rounds, do you see them all day?

A. Yes.

Q. I would assume that on occasion those overlap; you may get called to the ER ...

A. I might. Yes.

Q. ... or vice versa?

A. Yes.

Q. Okay. In Guysborough in your practice, have you ... well let me ask you generally first. How many patients or how often would you see patients with mental health difficulties? Not necessarily acute, just generally speaking mental health difficulties.

A. In the office?

Q. Yeah.

A. Yeah. One or two per day, or in a week we will see four, five per week, but they may not be new cases. We are seeing the follow-up.

Q. Sure. Okay. And what types of mental health difficulties would you see amongst your patients?

A. Most of the time people have anxiety, depression, and some ... I have a few patients with history of PTSD and one or two patients I have ADHD. And also, one or two psycho- ...

schizophrenia patients.

Q. The last ... the last one?

A. Schizophrenia, psychosis.

Q. Psych- ...

A. Psychotic, yes.

Q. Patients suffering from psychosis?

A. Yeah.

Q. Okay. So you say you do treat some or you see you some patients with post-traumatic stress disorder?

A. Yes.

Q. Do you have or in your practice have you seen any military or ex-military patients?

A. I had only one patient, Mr. Desmond. Lionel Desmond.

Q. He was the only military or ex-military patient?

A. Yes.

Q. What about other emergency or first responders? So, for example, police officers, firefighters? Do you see patients or have you?

A. I have a few patients of them.

Q. Have you ... are you familiar with the term "occupational stress injury" or "operational stress injury"?

A. No.

Q. Not ... those aren't commonly-used terms in your practice?

A. No.

Q. No? You said, Dr. Ranjini, that the only patient that you had seen with a military background was actually Lionel Desmond.

A. Yes.

Q. And you did see him and treat him on a couple of occasions?

A. Yes.

EXHIBIT P000092 - RECORD FROM GUYSBOROUGH MEMORIAL HOSPITAL EMERGENCY CARE RECORD

Q. Okay. Perhaps we can ask you about that. We have the records from the Guysborough Clinic, so perhaps we'll go through these. And for the purposes of the exhibiting, we'll be looking at Exhibit 92 and we'll start at page 4.

So what I'm going to look at or direct your attention to is a visit that you had with Lionel Desmond on August 13th, 2015.

A. Yes.

Q. Are you familiar with that record?

A. Yes.

Q. Okay. So I'm going to ask you a couple of questions

about this document. First of all, can you tell us what this document is, page 4 of Exhibit 92?

A. He presented to the emergency department with a history of bee stung in the ... behind ... below the left eye and he has a local allergic reaction. So he was stable and his vision good and I didn't see any acute prob- ... you know, that is the routine.

Q. Okay. So the document itself is a record from the emergency department, is it?

A. Yes.

Q. At the Guysborough Hospital?

A. Yes.

Q. Okay. And it's from August 13th, 2015 ...

A. Yes.

Q. ... I see in the upper left-hand corner. And the time that he presented there was what?

A. 1:39. 12:39, sorry.

Q. 12:39. So that would be 12:30 in the afternoon?

A. Yes.

Q. Okay. At that time, had you met Lionel Desmond before? Did you know him?

A. I met him I think that is the first time.

Q. Okay. Now obviously you've been practising there in Guysborough since 2005.

A. Yes.

Q. You may have met him in the past?

A. I'm not sure because he wasn't living in Guysborough, so I'm not sure I did see him in the past or not.

Q. Okay. So to your recollection that was the first time you had seen him?

A. Yes.

Q. So ... and he presented at the emergency room, I guess, at the Guysborough Hospital?

A. Yes.

(09:50)

Q. When he presented, he would, I assume, be triaged by a nurse first would he?

A. Yes.

Q. Okay. And maybe - can we just bring the document up again? So the writing that we see in the middle of this document under "Triage Assessments" "Stung on left eye" it looks like, would those be the notes of a nurse or ...

A. Yes.

Q. ... your notes?

A. Yes.

Q. They would be a nurse's notes?

A. Yes.

Q. Okay. So the practice I take it in the hospital is to have ... as in I suppose any hospital is to have a patient triaged first?

A. Yes.

Q. Okay. Now this ... just up from there, there's a triage code, I guess you would say, the 1, 2, 3, 4, 5. Are you familiar with those numbers and ...

A. Yes.

Q. What do those numbers mean?

A. If something really people have cardiac arrest I should be there right away, that is 1. And somebody come with chest pain, they think it is heart attack, kind of, we should go, be there, whatever, they call me and I will be rushed to go there. And 4 is they could wait for about an hour or so. 5 is actually a office visit; that is not really an emergency but they come, we see them.

Q. Right. Okay. So this was designated or assessed as a 5, was that by the nurse?

A. Yes.

Q. Okay. So it wasn't urgent, it was really more of an office visit?

A. Yeah.

Q. But he presented at the hospital at the emergency room?

A. Yes.

Q. Did Lionel Desmond seem to have or feel he had a family doctor? Was he your patient at that time or a patient of the clinic?

A. He most probably our clinic patient. A lot of people see Dr. Foley as their family doctor but he presented my name, but we all see our patients most of the time.

Q. Okay. So basically anyone growing up in Guysborough would probably consider Dr. Foley their doctor at one point in time?

A. Yes, most of the time before we came here so ...

Q. Okay. He presented however, at the emergency room and it was at 12:39. So would you have been in the emergency room at that time or would you have been in the clinic?

A. I was doing my office, so that is our break time coming soon but I need to finish my office patients. So as he is not in any acute distress so I finish my office and went to

see him afterwards. So ... yeah.

Q. Okay.

A. Before the morning visits of my office patients.

Q. Okay. You saw him ...

A. 1:45.

Q. Okay, you saw him after you finished your morning patients?

A. Yes.

Q. Okay. Now he presented with a ... you said a bee sting ...

A. Yes.

Q. ... on his eye or under his eye?

A. Under the eyelid, like a maxillary area here.

Q. And what area is that you're saying?

A. This is the area called maxilla ... maxillary area, so under the lower eyelid.

Q. Okay. And so when you did see Lionel Desmond what did you make of him? What did you ... what impression did you have of him?

A. He was a very pleasant man but he came for the local allergic reaction.

Q. Okay. Did you make any other observations of him? I

appreciate you were there to treat him for a bee sting but ...

A. Well he was really pleasant and very ... I couldn't make any different on him to think anything is acutely going on wrong.

Q. Okay. Now just on that form again. In the triage ... I guess it would have been filled out by the triage nurse to the right under "Medications" there's a number of medications listed there. Those would have been entered by the triage nurse, would they?

A. Yes.

Q. Okay. Are you familiar with some or all of those medications?

A. Yes.

Q. Okay. So zopiclone, for example, is for what?

A. This is used for sleep.

Q. Okay. And risperidone is?

A. Risperidone is the anti-psychotic medication. People use it for different purposes.

Q. Okay. So it isn't always used as an anti-psychotic, it has other uses?

A. Yes.

Q. What are some of the other uses?

A. If somebody have resisting depression we use it, or somebody couldn't sleep like we support those medication for sleep with adjusting medication to adding on with the other one.

Q. Yes.

A. Yeah.

Q. Okay. And Effexor is ...

A. Effexor is anti-depression.

Q. Anti-depressant, okay. And the last one I'm having a little trouble reading, do you know what that is?

A. Viagra.

Q. Oh, Viagra.

A. That is for sexual dysfunction.

Q. Right, okay. So the fact that Mr. Desmond was on those medications, given that he was there to be treated for an eye injury, would that have had any effect on how you treated him? Would that have been relevant at all or would the nurse simply have gotten whatever medications he was prescribed?

A. Because we see those medications if I'm going to prescribe any other medication, maybe in direction with this medication, so that is one reason we have it. And also we have this one for person taking and his medication history.

Q. Okay. Ultimately, you prescribed Benadryl I think ...

A. Yes.

Q. ... for the allergic reaction?

A. Yes.

Q. And that would not have had any ...

A. No.

Q. ... negative interaction with those other medications? Okay.

A. No. Usually not.

Q. Okay. Do you have a recollection of how long you might have been with him for that visit on that day?

A. 15 ... less than 20 minutes, 15 minutes, something like that. But he may ... I would ask the nurse to keep him for a little bit to see any other side ... not side effect really, any consequences of sting bite, any further allergic reaction, like anaphylactic reaction, but if it's going to happen it would have happened within one-hour period before I see him ...

Q. Okay.

A. ... or around that time. Half an hour most probably people develop any bad reaction ...

Q. Right.

A. ... that would have seen, so ...

Q. Okay. So typical with an allergic situation ...

A. Yes.

Q. ... you watch them for a bit?

And I take it on that occasion there wasn't any discussion about his personal circumstances, history, any of that?

A. No, I didn't ask.

Q. Okay. His address on that form is listed as in Oromocto, New Brunswick. I don't know if that would be something that would even have stood out to you, that he had a home address in Oromocto? It may not have, I just ...

A. No, I didn't pay attention for that.

Q. No.

A. Sorry for that but ...

Q. No, no, that's fine.

A. Because people come from anywhere for summer holidays to our area, so people come from all over the world sometimes.

Q. Right.

A. So I didn't do any question for specific address.

Q. Right. Especially in the summer in Guysborough it would not be uncommon to have people from outside the area? Okay.

So you said he presented on that occasion to the best of your memory as a pleasant person?

A. Yes.

Q. And there was nothing else about his demeanour or presentation that stood out to you?

A. Nothing makes me think something different going on.

Q. Now you next saw Lionel Desmond or the next record of a visit with Lionel Desmond is from over a year later, that would be November 2nd, 2016. Is that correct?

A. Yes.

Q. Okay. So that's again Exhibit 92, now page 9?

A. Yes.

Q. So again we see a document that looks like the earlier document, so again that's a Guysborough Memorial Hospital Emergency Care Record?

A. Yes.

Q. Right. And again, that was filled out as a result of a visit to the emergency room of the Guysborough Hospital?

A. Yes, but patient has an appointment in the office. I was called in for emergency in the hospital ...

Q. Yes.

(10:00)

A. ... so I was running late so, therefore, the patient was sent to emergency department to see me, so that's why

patient was presented in the emergency department.

Q. Okay. So you say on this occasion, Lionel Desmond actually had made an appointment ...

A. Yes. He was waiting in the office, I need to come to the ER. So ...

Q. And the time noted on this is 18:15, I believe. So that would be ...

A. Yes.

Q. ... 6:15 p.m.?

A. Yes.

Q. Would you normally be seeing patients in the clinic that late or were you backed up because of the emergency?

A. No. We see them up to 5, 5:30. Then on the other day I was called in I couldn't able to return back to see the patient on time. So the office close. They must have wait little longer. I could go. I couldn't able to make it back. So they call me how long it takes. Then they told me the patient waiting there. So if somebody wanted to see me I always ask them to come to the hospital. I will continue to finish it.

Q. All right, so you were able to see him, then, in the hospital as opposed to going back to the clinic.

A. Yeah, because there is nobody going to be there. The

secretaries would have gone.

Q. Right, so that was at 6:15 he was seen, then, by a nurse first?

A. Yeah, she did do some vitals and those kind of stuff.

Q. Now Lionel Desmond's address at this time is a Guysborough address. Again, would not be significant to you, I take it, where his address was?

A. Patient comes, I see them so ...

Q. Sure. Yeah. No, no, that's fine. Did you remember him from the year before?

A. I know him, like, as a community member kind of. Not direct interaction. So ...

Q. For example, would you know his family or members of this family, perhaps, or ...

A. I know the family.

Q. Okay, so on this occasion he's seen by the nurse initially. You said she took some vitals, which I take it would be a normal procedure when someone presents?

A. Yes.

Q. Okay. And again, there seems to be triage code of 5. That's because it was an office visit.

A. Yes.

Q. All right. And the triage assessment simply says, "Patient to be assessed by Dr. Ranjini." Do you recall on this occasion, if you do, whether he came with anyone or whether he was by himself?

A. I remember he was sitting alone in the waiting area and I did take him in. I apologized because it too long him to wait because I ... I didn't purposely do it because I was in the emergency. I ... he understood that part.

Q. He understood it.

A. I was doing something, emergency work, in the hospital.

Q. Right. Okay. But he was by himself to the best of your recollection?

A. Yes.

Q. When someone makes an appointment as Lionel Desmond had on this day to see you in the clinic do you get any information ahead of time about what he's made the appointment for or why he wants to see you?

A. No. No.

Q. Okay, so it's just an appointment. You have no idea.

A. No.

Q. Okay. Now you saw him in the hospital. Would you

have had access to his ... I assume when you're seeing patients in the clinic you have a running chart or a running file for them?

A. Yes.

Q. Would you have had access to that when you him on November 2nd?

A. No.

Q. And that's because you were in the hospital in the emergency room?

A. Yes.

Q. If you had been in your clinic would you have had access to that?

A. Yes.

Q. If you had needed to access it could you have done that?

A. Usually I don't go back to the office if nobody there.

Q. Okay. Now apart from your file at the clinic that you may have had on Mr. Desmond, would you have had access to any other databases or electronic records in the hospital?

A. At the time we don't. We have now.

Q. Okay, so at the time, no. What do you have now in the Guysborough Hospital? What access ... you have access to a

database now?

A. We have, yes.

Q. And what is that?

A. Patient history and ...

Q. Do you know what the system is called or what the database is called?

A. Accuro. Emergency ... Accuro. We use it, like ... I'm sorry. I can't tell you.

Q. That's okay if you're not ...

A. The company name is Accuro.

Q. Accuro?

A. Yes.

Q. Okay. Can you spell that out for us?

A. A-C-C-U-R-O.

Q. Accuro. Okay, and is that an acronym? Or does it stand for anything do you know?

A. No.

Q. Okay. And what does that system give you access to?

A. I could see the family doctor ... if he is our patient we have patient record. Like his notes if I see him. The patient history and physical and his bloodwork, x-rays and other specialist notes if you see him. We would have seen.

Q. Those are notes from your clinic are they?

A. Yes.

Q. I see. Okay. So you have the system that you use at the clinic and enter that information into the system?

A. Yes.

Q. I see. So when you see a patient at the clinic do you make notes by hand? And are they scanned in? Or do you type them in? What's your practice?

A. I still use the paper chart.

Q. And those are scanned, are they?

A. No.

Q. Okay. So if another doctor wanted to see your notes they would look at the paper chart, would they?

A. Yes.

Q. Do other doctors type their ...

A. Yes.

Q. Their notes?

A. Other ...

Q. And those ...

A. Yeah. Yes.

Q. ... go into the Accuro system?

A. Yes.

Q. Apart from that system that you have at the clinic are there other systems available to you in the hospital part of ...

A. Yes, we have EMR, Emergency Medical Record, in the hospital.

Q. All right. And what will that system give you access to?

A. I have access to outpatients' department notes and some doctors' notes. Some procedures. Sometimes available, sometimes not.

Q. Okay. And is that the outpatients only at Guysborough or in other hospitals as well?

A. Other hospitals, too.

Q. Do you know which hospitals?

A. We have St. Martha's Hospital and maybe Canso. Those kind of places.

Q. Okay. St. Martha's, Canso. Not all of the province though.

A. No.

Q. No.

A. But we could check. Recently on SHARE somebody have something done in Halifax. We could see it.

Q. And that's on the SHARE system?

A. Yes, but these all really latest. Not at that time.

Q. Were either of those systems that you've just made reference to, were they available in 2016?

A. EMR is there but other one recently we could able to see it.

Q. The SHARE system is more recent?

A. Yes.

Q. Okay, so on this occasion, then, because you happened to be at the hospital and not in the clinic you didn't have ready access to your own file for Lionel Desmond.

A. I didn't see him before so I don't have any notes.

Q. Right.

A. Yes.

Q. Other than this bee sting from a year before.

A. Yes.

Q. Okay. Now at the time in 2016 there were other doctors working in the clinic, were there?

A. Yes.

Q. And who else was working in the clinic at that time?

A. Dr. Ali Khakpour, and Dr. Harnish was work- ... we have some locum doctors come and work. And Dr. Bell.

Q. Okay, so Dr. Bell that you've mentioned earlier was

working there at the time. The other full-time doctor was Dr. Ali Khakpour?

A. Yes.

Q. Okay. We're going to hear from him. And then you said other doctors would come in and do locum?

A. Yes.

Q. Or loc- ... I don't know what the word is but ...

A. They come and help us, yeah.

Q. Okay. The doctor that you mentioned who came and did the ... was doing locums at the time, what was his name?

A. Dr. Harnish.

Q. Dr. Harnish? Okay.

A. I don't know the full name, sorry.

Q. That's okay. And do you have ... did you have other doctors that would come in and fill in?

A. Yes, time to time some people come but I couldn't tell all the people. Recently we have Dr. Adeola regularly comes and works with us.

Q. Okay. And when a doctor comes in and does a locum to assist what would they do?

A. Whatever we are doing most of the time, they do the same.

Q. So would they see patients in the emergency room?

A. Yes.

Q. And would they see patients in the clinic?

A. Yes.

Q. So basically, whatever your day would be ...

A. Yes.

Q. ... they would do your day.

A. Yes.

Q. Okay. Now if a person, a local person let's say, calls for an appointment at the clinic would they typically see one of you or the other or whoever is available?

A. If it is my patient, if I'm there, I will ... I see them. If somebody else patient, like say Dr. Bell's patient, Dr. Bell is not there, I will see them if I need to. If it's an emergency or patient wanted to see, I will see them.

(10:10)

Q. If I lived in Guysborough and I was a patient at the clinic would I typically be either your patient or Dr. Bell's? Like I would be designated as the patient of one or the other?

A. Yes, most of the time.

Q. Okay, so if a person came in who was a patient of Dr. Bell's, let's say, would you be able to access the notes from

Dr. Bell?

A. Yes. Yes.

Q. Would that be on the database that you mentioned or a physical file?

A. Yes. Yes, and also, patient ... because we started this program in 2013 and ... in latter part of 2013. So yeah, before that everything is paper. Was paper.

Q. Would you know if a patient had seen one of the other doctors by ... you would have to look at the paper file and the electronic file to know if they had seen the other doctor?

A. Yes, but my patients only have paper chart. Other people have ... they change to the Accuro system. I am sorry I didn't remember the name called for that program, so ...

Q. That's okay. If a patient was a patient of yours but had seen, for example, Dr. Harnish previously on a locum would ... how would you know that that patient had seen ...

A. They write it down in the chart, "See EMR." So I know that is in the computer.

Q. So you would have to look at the paper file. There would be a note directing you to the electronic file?

A. Yes. Yeah, it is called Electronic Medical Records.

Q. Electronic ...

A. Sorry.

Q. ... Medical Records? Okay, so on this occasion, though, Lionel Desmond comes in and you ... other than seeing him this one time of year before for the beer sting, you had not seen him before.

A. Yeah. No.

Q. Okay. And you didn't have his paper file there at the time. Do you recall if you spoke to him about whether he had seen any of the other doctors at the clinic?

A. No. He didn't mention. I didn't ask either.

Q. And would you typically ask? Or would you ... or would it depend, I guess, and if so on what?

A. Depending on the history but I didn't ask.

Q. Okay, so it looks like he did actually see Dr. Harnish on the 13th of October and it seemed that there's an electronic record. But unless he told you that, or you would have had reason to look, you wouldn't know that?

A. No.

Q. Okay. And if you see a patient in the hospital, such as you did on this occasion, would you have access to EMR like ...

A. Yes.

Q. The electronic database?

A. Yes.

Q. So on November 2nd what did Lionel Desmond come to see you about?

A. He is here for his PTSD and he was telling he is known to have PTSD and he was working ... he's a overseas veteran, he told me, and he was talking about what happened during the time and how bad his flashbacks and the dreams and he couldn't able to sleep.

Q. Okay. So just at the outset, do you recall how he presented when you first met him on that day?

A. He was so pleasant, cooperative, and calm, psychomotor, there is no agitation, no distraction, and he was talking to me full sentences. He had a good eye contact. I didn't see any negative things on him when I was talking to him.

Q. When he presented with a mental health difficulty like PTSD and the symptoms from PTSD I assume there are some things that you would look for right off the bat when you're dealing with him, speaking to him. For example, you said that you looked for some psychomotor symptoms like agitation. Why would you look for that? What other things would you ...

A. That is the routine mental examination, mental health

exam, to assess how they looks like and how the presentation was.

Q. What are some of the things, then, in a routine mental health examination that you would look for?

A. Somebody depressed or agitated and their affect looks like so happy or so sad or nervous and those kind of stuff. His affect and how they presented like their posture or they are dressed up and eye contact and those kind of things.

Q. And why would you look for those things?

A. Those things ...

Q. What would they tell you?

A. Those things give us some idea about patient, how badly affected or how acutely he is having problem going on.

Q. So, for example, if a patient is unable to make eye contact with you, what might that tell you?

A. That means he is having something really wrong. Maybe he has some thoughts or he is going through something different. Those kind of stuff or ...

Q. When you ... and the nature of the examination when someone presents with a mental health difficulty, can you give us a sense of how that session would go? Is it ... do you ...

A. I listen to him most during the session, what he was

talking. So ...

Q. And would you both be seated?

A. Yes.

Q. What would you ask him, I guess, to start the session? How would you begin to investigate?

A. I apologize to him first because I was seeing him late. Then I ask him open-ended question, How could I help you? Then he started talking.

Q. And as he talked you assessed some of those things you just mentioned?

A. Yeah. I could see, visual observation, those other things.

Q. So those things that you just mentioned, what was your visual observation of Lionel Desmond? How did he present to you?

A. He was so pleasant and he wasn't in any distress, acute distress.

Q. And you say ... why do you say he was not in any acute distress?

A. His mood is ... his affect is ... doesn't look like sad or agitated or nervousness and he is calm. He has a very good eye contact and he dressed up normal. I couldn't remember

what he put it on. I couldn't recall, but he doesn't look like anything suspicious or make him think he is not having ... he is having some problems. Other than his ongoing PTSD symptoms and flashbacks.

Q. So you obtained something of a history from him when he said he had PTSD from being in a war zone. How would you do that? Would you let him tell you that or would you question him?

A. I asked a open-ended question, How could I help you? Then he started talking.

Q. Do you recall what he told you of his experience?

A. I couldn't remember too much to tell. I did remember saying about children and that reminds him of his daughter ... that ... I really remember that part.

Q. Okay, and I think you actually ... perhaps we could just put the note back up. Can you just tell us what you wrote there?

A. "Him here with the known history of PTSD. Seeing Dr. Slayter. Having a lot of dreams. Overseas veteran. No physical problem he told me. And he had a good insight. He wanted to be feel better." But I didn't finish that sentence. "He was very pleasant, not in any acute distress. His ...

clinically, he is stable." Like no medical health issues.

Q. Okay, so that says, "Not in acute distress." The next words ...

A. "Not ..."

Q. ... are, "Not pale."

A. "Pale. No dehydration. Heart sounds good. No murmur. Lungs clear." I planned to refer him to Dr. Slayter.

Q. Okay, so you said a moment ago what he told you or what you recall of what he told you about his experience in the war related to children?

A. Yes.

Q. Okay. And he made reference to his own child?

A. Yeah, that's why I remember.

Q. Okay.

A. I'm really sorry but ...

Q. Would you obtain a family history from him as well?

A. No.

Q. No? Did you learn anything about his family situation other than that he had a child?

A. No, but ... no.

(10:20)

Q. Okay. When a person is ... presents with mental

health difficulties is it helpful in some cases to find out about their living situation, their family situation?

A. Yes, but the patient is not having any acute distress. So I didn't think about asking those questions.

Q. So you say you asked open-ended questions and he told you about his experience in the war.

A. Yes.

Q. And then told you about the symptoms that he was experiencing?

A. Yes.

Q. And what ...

A. Flashback of what he's experienced in the war zone and he has the same thing coming as the dream ... dreams.

Q. Oh, as a dream. Okay, so how did he describe the flashback? What did he say to you about the flashbacks?

A. I couldn't able to recollect, but I only remember the children remembered him to her daughter.

Q. Okay, and you say he was experiencing the same thing in dreams?

A. Yes.

Q. Okay. And you said that ... earlier on in your evidence you said that you have treated patients with PTSD. Are

flashbacks and ... intrusive flashbacks and dreams, are those typical of patients with PTSD?

A. Yes. Yes.

Q. Are there other symptoms in your experience that are typical of post-traumatic stress disorder?

A. Sometimes people are agitated, but this patient is not. **Q.** Did he describe any other symptoms to you that he was experiencing?

A. No.

Q. Okay. Are there other symptoms that you might probe a little bit about? Like some patients may have ...

A. Anxiety, depression kind of.

Q. Anxiety and depression. Did you discuss that with him or did he say he was having any of those problems?

A. I didn't explore that much.

Q. Okay. He ... your chart says that he came here with a known diagnosis, I guess, or known history of PTSD?

A. PTSD, yes.

Q. So was it your understanding he had been diagnosed with post-traumatic stress disorder?

A. Yes, because he did see one week ago Dr. Slayter. He is the psychiatrist. So ...

Q. How did you find out that he had seen Dr. Slayter?

A. He told me.

Q. Did you ask him or was that something he volunteered?

A. He volunteered, yes.

Q. Did he say anything about that, where or how he saw Dr. Slayter, or for what?

A. He didn't say but he said he was started on new medication. He couldn't able to remember other medication. He only said the trazodone, and I don't have any answers to find out what other medications and the dosage because our pharmacy closed at 5:30 and I couldn't access the notes of Dr. Slayter at the time.

Q. Okay, so a couple questions about that. He said that he had started on a new medication?

A. Yes.

Q. And that was trazodone, was it?

A. Yes, and also, he was telling other ... some other medication, but he couldn't remember and he couldn't able to tell me.

Q. Okay, but was trazodone the new medication or was that one he was already on?

A. I'm not sure.

Q. Okay. In your experience, what is trazodone for?

A. Trazodone for ... it is an antidepressant and also give it for people to sleep.

Q. Is that a medication, in your experience, that might be prescribed to patients with PTSD?

A. Usually PTSD is the treatment of symptomatic management. If somebody not sleeping, sleeping medicine. If somebody agitated, for agitation. Somebody depressed, we give the depression medication and so on. But ... and also with this medication they need to have psychotherapy, right?

Q. They need ...

A. Psycho- ... psychotherapy. Like CBT or ... they need to see the psychologist in order to get the talk therapy.

Q. Okay, so in terms of the meds, the medication, as you say, are symptom management. So interrupted sleep may be common with PTSD?

A. Yes, because of the dreams, they couldn't able to sleep.

Q. So a sleep aid or a sleep medication might not be uncommon with PTSD?

A. Yes. Yes.

Q. On our ... on the form from November 2nd, the

medications are not listed. There were medications listed in the August 2015 chart from the nurse. On this occasion is there any reason why meds weren't listed? He ...

A. Because he came from the office, the patient told he is here to see me. So most probably the nurse didn't do any of her assessment. That's why it is not there.

Q. Okay. In any event, the only medication he could recall was trazodone.

A. Trazodone, yes.

Q. And you said a moment ago that because of the time of day, you didn't have access to the pharmacy.

A. Pharmacy. No.

Q. Would you be able to determine a patient's prescriptions by accessing the pharmacy with their consent if they came to the ... see you?

A. We usually call the pharmacy and, at the time, get their information to fax it but ... yeah.

Q. And that's a local pharmacy in Guysborough is it?

A. Yes.

Q. Is there only one?

A. Yes.

Q. Okay. So most patients in Guysborough would fill

their prescriptions ...

A. Go ... yes.

Q. ... in that one pharmacy?

A. Yes.

Q. Is there any other way to get a patient's history of medication if they don't recall it themselves?

A. Yes, otherwise they see other doctors. Then their notes available. There will be.

Q. Sorry, I lost that last one.

A. If they see other doctors, then if I could able to see their notes there will be ... maybe there will be a medication listed.

Q. Okay. When you met with Lionel Desmond did he make any comments to you about his medication?

A. He told me that medications are not helping.

Q. And did he say ... without ... I appreciate you didn't remember the names of the medications, but did you get a sense from him what they were for?

A. No.

Q. No? And ... but he said that they weren't working?

A. Yes.

Q. Okay. Do you recall him saying anything else about

what the problem with his medications were?

A. He was taking the medications. He didn't mention any side effect or anything like that.

Q. Okay, so he didn't mention a side effect, just that he didn't find them effective.

A. Yes.

Q. So you were talking to him, asking him open-ended questions. What else did he tell you, do you recall?

A. I don't think anything different.

Q. In total, do you recall how long you were with him?

A. 25 to 30 minutes.

Q. Is that about ... perhaps this is an unfair question. I was going to say is that typical but every patient and presentation was different, but to get a history for a mental health patient that you haven't seen before, how long would you normally spend with them?

A. Around that time. Sometimes more than that. If somebody really acutely distressed and suicidal, then I will get more details and more history.

Q. At some point after you've asked open-ended questions do you start to ask probing questions like, Tell me about this or ...

A. Yes.

Q. And what types of specific questions might you ask the patient?

A. I couldn't recollect ...

Q. One of the things you said in assessing whether a person is acutely ill is determining whether they're suicidal?

A. Yes, I did ask that question ...

Q. So tell us about that. How would you ask that?

A. If somebody come with a mental health disorder or issue I always ask suicidal or homicidal history in order to decide whether they are safe to go home or I need to transfer him or get the help from psychiatrist. So most probably I asked but I didn't write here. I'm really sorry for that, but I usually ask direct questions that are ... Do you have any thoughts of hurting yourself or you have any plan to kill yourself? Same way I ask, Do you have any thoughts about hurting others or killing others. I ask, like, that direct question.

Q. Are those standard questions in a mental health examination?

A. Yes, I always ask like that.

Q. You always ask those questions? And we've heard this

from other doctors, as well, similar to what you're saying. But you come right out and ask the question in that way?

A. Yes.

Q. Do you assess suicidal ideation in other ways, as well, in an interview?

(10:30)

A. Depending on somebody say, I'm suicidal, then I will ask how long you have it and what makes you think to do that or any plan for it or do you think your life is not worth living or something like that. Anything makes them worse or anything makes them feel better. Those kinds of questions, I will ask. But he ... I feel like he did tell me he doesn't have any suicidal or homicidal thoughts, so I didn't explore further.

Q. Okay. If those had been seen by you; for example, if there was something that caused you concern, would you have noted that in your chart?

A. Yes.

Q. Even if it wasn't to the point of hospitalizing somebody.

A. No. If somebody says, I'm suicidal, or, I have thoughts, I definitely would have write it down.

Q. Okay. And we've heard in the past about protective

factors for suicide, things that make suicide less likely. Family support or social supports, those types of things. Are those things that you think about when you're talking to a patient in relation to suicide?

A. It's ... yes, depending on how sadly or how badly they are depressed or agitated, and any stress at the time they ha- ... if they say, Yes, I will go deep into that.

Q. Was Lionel Desmond forthcoming with you when you asked him questions?

A. Yeah, he was cooperative. He was talking to me as a normal person talking to me.

Q. Okay. And did he ultimately say what he wanted from you?

A. He ... for me, he has insight. He understands he has a problem. He wanted to feel better. So my understanding, he is taking medication. It started last week, some of them, and seen by the psychologist ... psychiatrist. So he needs ... his medical care needs beyond my expertise, so I decided he needed to have specialized expertise care. So, therefore, I did send a letter to Dr. Slayter to have an assessment and psychologist, multidisciplinary system, to get involved in his care.

Q. So you said that he needed specialized care for his

PTSD and his symptoms?

A. Yes.

Q. Would there be a situation where somebody presented to you with a diagnosis of PTSD where you would treat them yourself in Guysborough or would they always be referred to a specialist?

A. No. Depending on their background and also how they wanted to do it. And, also, in his case, he's a military veteran and he has bad dreams and flashbacks and he is getting only medication. He is not getting any other form of treatment, like, he needed psychotherapy or he needed to be seen by a psychologist. We usually send them to a specialist and they go through that part.

Q. So he needed to see a psychiatrist for medication for symptom management and also needed to see a therapist for psychotherapy?

A. Yes. And, also, if there is any additional complaints or additional diagnosis which, I may miss it, so that's why I did. For the assessment and multidisciplinary team to get involved in his case, that's why I did send the referral.

Q. Okay. So a couple of questions about that. You said a moment ago that in your understanding, a person with PTSD really needs the psychotherapy.

A. Yes.

Q. And you mentioned one of the treatments. CBD, I believe.

A. CBT. Cognitive behavioural therapy, yeah. I'm not in that part, expertise, but I'm not sure what else they offer for the people.

Q. Right.

A. But one of my ... I don't want to talk ... yeah.

Q. No. I appreciate you don't want to talk about current patients but, more generally, in your experience, are there therapists in this area that will assist people with, for example ...

A. Usually ...

Q. ... cognitive behavioural therapy for PTSD?

A. Yes. St. Martha's.

Q. At St. Martha's, okay. Now you said he needed this and it was your understanding that he had seen Dr. Slayter about a week before?

(10:40)

A. Yes.

Q. Did he tell you anything about other treatments he had had or other people he had seen?

A. No. He didn't open up anything.

Q. So did he tell you, first of all, when he may have left the Canadian Armed Forces?

A. No.

Q. No? Okay. Did he tell you, or were you aware, of any of the treatment he had while he was in the Canadian Armed Forces?

A. No.

Q. And, similarly, when he lived in New Brunswick after being released, did he tell you about the treatment he had received there?

A. I didn't know any of those.

Q. Right. And you wouldn't necessarily have any way of knowing but he had been treated at Ste. Anne's Hospital in Quebec for post-traumatic stress disorder and other conditions that he didn't ...

A. He didn't tell me ...

Q. ... tell you that?

A. No.

Q. Okay. And did he tell you, or did you discuss with him, whether he had a case worker from Veterans Affairs?

A. No.

Q. No. And you said he was really the only military patient or ex-military patient, to your knowledge, that you had ...

A. He said, Yes, he's a military veteran.

Q. If you had known any of that or that information had been available to you, would that have changed anything?

A. I understand, at that point, he need more ... beyond my expertise. He needed further treatment and assessment. So even I see it, I will definitely refer him to see the specialist.

Q. Okay. All right. The starting point for that was your referral to Dr. Slayter?

A. Yes.

Q. Was Dr. Slayter the person, typically, that you might refer a patient like Lionel Desmond to?

A. No. He did see Dr. Slayter. That's why I sent the letter to Dr. Slayter.

Q. Okay. And in terms of the other part of that, the psychotherapy, how did you see that coming to happen?

A. Usually, when they see the psychiatrist, everything organized with the people in St. Martha's so ...

Q. Including therapy.

A. Yeah.

Q. If you needed to see a counsellor or a psychologist?

A. Everything available in St. Martha's, so ...

Q. A couple of other things about your note. You had said, "No physical problems."

A. Yeah. He mentioned ... I asked, Anything else I could help you with? He said, No, no physical com- ... I asked those.

Q. Okay. So when you're seeing a person for mental health difficulty, how much would you normally ask about their physical condition?

A. I ask the question, Any other questions or anything else? Then they will mention if something else.

Q. So you asked that question, did you?

A. Yes. I always ask any ... once I'm done, Anything else you want me to do or anything else you want to talk to me?

Q. Okay. And his answer to the question was?

A. He agreed with me to referral to send Dr. Slayter. I told him, You need treatment from psychologist and other specialist, so you need to be seeing Dr. Slayter.

Q. Did he make any reference to having had head injuries or having ...

A. He didn't.

Q. ... head concussions?

A. No.

Q. Did he make any reference to having had a back injury?

A. No. That's how the "no physical complaints" came.

Q. When you said that your plan or your recommendation was that he be referred to Dr. Slayter, what was his reaction to that?

A. He agreed with that.

Q. And, again, you had said that there wasn't really a family history that you'd gotten on that day, so I take it there was no discussion of his relationship with his wife on that day?

A. I didn't ask specifically. I know he has a wife but I didn't ask specifically.

Q. How did you know that he had a wife?

A. I know from the community but ...

Q. Okay. At the time, did you know that?

A. Yes.

Q. Okay, all right. Knowing that he had seen Dr. Slayter a week before, did you know that he had seen Dr. Slayter at St. Martha's or at an office visit or ...

A. I didn't know that.

Q. Okay. Would you have had access to Dr. Slayter's record from the week before had you wanted it?

A. I didn't have at the time.

Q. Okay. And would that have made any difference if you had ... you were going to refer him back to Dr. Slayter in any event.

A. Yes, I will. I did.

Q. You did, yeah. Would having had access to Dr. Slayter's chart note from the week before, would that have been of assistance to you?

A. Yes or no, because he ... the medication started a week ago, so may not be I'm going to change the medication.

Q. We know that he previously had other diagnoses, like major depressive disorder. Did he mention to you that he had been diagnosed with depression?

A. No. He didn't say anything. He only said to me he'd known diagnosis of PTSD and flashbacks and the dreams and couldn't able to sleep. Those are his main problems and ...

Q. So as a result of ... first of all, I should ask, was there anything else about the visit that you recalled?

A. No.

Q. Is that "no"?

A. No.

Q. You did, in fact, make a referral to Dr. Slayter?

A. Yes.

Q. And that's in our exhibit, I think, at page 10. Do you recognize that document at page 10?

A. Yes.

Q. And what is that document?

A. I ...

Dear Dr. Slayter: (the psychiatrist)

I saw Mr. Desmond, Lionel. Very pleasant. 32-years old. Overseas war veteran. Having symptoms of PTSD and (I'm sorry, I put 'she' but he) saw you last week. He was started on trazodone and new medication. Patient doesn't remember. Could you please see him and advise?

Q. Okay. And the date of your letter to Dr. Slayter is there at the bottom.

A. 2nd of November 2016.

Q. So that's the same day that you saw him?

A. Yes.

Q. Okay. How would you normally send that to Dr.

Slayter? Would that be a fax or ...

A. Fax it. Next ... depending on the time. During the daytime, they will fax it, but in the night, if we have a fax number, we will fax it through. The nurses will do it. And if we don't have it, we will wait for next day, morning, to call and get the number to fax.

Q. Okay. And the patient will then be asked to follow up or will receive a call?

A. I always ask them to return, especially mental health issues, return to the emergency department or call us if anything changed but I didn't have a written note and I'm really sorry.

Q. You always ask them to ...

A. Yes, that is my ...

Q. ... follow up with you?

A. ... routine, yes. Routinely ask all these questions.

Q. So in the case of Lionel Desmond, did you ask him to follow up with your clinic again?

A. Yes.

Q. And what's the purpose of that?

A. Because if may have any suicidal ideations, he may not see the doctors within a certain period of time, or something

like that, or any people can have ... mental health people, I'm really worried about suicide, homicide things, we all, so that's the reason we ask them to call us or come to the ER if they need it.

Q. Do you typically give them a suggestion about how soon they should contact you? In other words, Call us back in a week?

A. If I start the new medication, I always follow up in a week or two time because ... if young people, I ask them to come every week. Somebody adult and they have family and support system there, I ask them two weeks' time because the medication started to kick in in ten to two weeks' time, but it's not full-blown. So, during that time, I ask to see them again, the people who ... to any improvement or any side effects from the medication and those things.

Q. Okay. Do you remember, specifically with Lionel Desmond, if you told him ...

A. Particular time, I didn't, because I didn't start any medication. He is not in any actual distress. He has ongoing problems. So I asked him, if there is any change, he needs to call us or come to the emergency department anytime.

Q. If there's a change.

A. Yeah.

Q. Now you had referred him to Dr. Slayter. Typically, when you would refer a patient, let's say, to a psychiatrist like Dr. Slayter, would you receive a report back ...

A. Yes.

Q. ... once the patient had seen him?

A. Yes.

Q. And, in this case, I believe he saw Dr. Slayter in early December. And I guess we're at page 11 of our exhibit. You received that document back, did you?

A. Yes.

Q. Or your clinic did?

A. We got it, yes.

Q. Okay. When you receive a report back - a fairly detailed report from a specialist, say, a psychiatrist like Dr. Slayter - would you have occasion to look at that document and to read it?

A. Yes, but I don't know when this was read. I don't have ...

Q. You don't know when it was received?

A. Yes.

Q. Okay, fair enough, but when it was received, would you

have ... I'm just wondering, from a practical point of view, would you have time to look through the whole ...

A. Oh yes.

Q. And do you recall looking through Dr. Slayter's letter back to you?

A. No, but I don't know how quick I did see that report. I couldn't recollect.

Q. All right. When you referred Lionel Desmond to Dr. Slayter, did you have a sense of ... I guess, appreciating he wasn't in acute distress, but how urgent it was for him to see the psychiatrist?

A. Usually, it takes time to see the psychiatrist, but he did see him in a one-month period. I think that is appropriate for the situation where I saw him, so ... if he is really in distress or something acutely something going on, I won't miss it. I always call the doctor on call, psychiatrist on call, and send them so ...

Q. Okay. And at the time that you made the referral, did you have a sense how urgent it was for him to also begin his psychotherapy?

A. I didn't have really, he is in acute distress to see the psychologist or psychiatrist right away, kind of thought. I

had it impression, so that's why I sent the letter.

Q. I've asked you a number of questions about accessing other records or being aware that your patient had seen other health care professionals. In your experience, especially working in a rural area, can that be a challenge finding out a person's medical history?

A. Yes.

Q. And, specifically, what types of things have you found challenging or difficult?

A. But if I send the patient to St. Martha's, we always get those specialist reports after they're done, but the psychologist or social worker or something like that, we usually don't get the notes from them.

Q. In Lionel Desmond's case, he had had treatment, obviously, outside of the Province of Nova Scotia and while he was in the Canadian Armed Forces.

Had that whole history been available to you ... I appreciate, in one office visit, you're not going to be able to read all of those notes or digest them all, but had the extensive history been known to you of his treatment, would that have changed anything in the way that you dealt with him?

A. Still, I will send a letter. I will ask them to see

him a little earlier than just a regular letter.

Q. So a slightly greater sense of urgency?

A. I would, yes ... see, I would write, Please see him earlier, the best possible. I might add that sentence.

Q. Okay. Do you recall if you made another appointment with him or if ...

(10:50)

A. No.

Q. ... on that day, on November 2nd?

A. I did ask him to come and see us, so return to emergency department if he needed.

Q. He subsequently did seek treatment for a cut finger in December and he saw Dr. Khakpour.

A. Yes.

Q. Were you aware of that?

A. Now I'm aware of, but, at the time, I was in the office. I may not see him coming and going so ...

Q. Right. And on December 20th, he saw Dr. Khakpour for symptoms of ... or continued symptoms of his PTSD. Again, at the time, would you have been aware of that or only after the fact?

A. After the fact because I wasn't ... I'm sorry to say,

I didn't know he's my patient but, suddenly, my name comes up as the family doctor, but I will continue to see him if he needs it but I didn't realize those kind of stuff.

Q. Again, I appreciate that Lionel Desmond's presentation was somewhat unique - his military background is not something that you commonly saw in Guysborough - but, more generally, when patients present with mental health difficulties in rural Nova Scotia and in our area of Nova Scotia, do you experience challenges in finding them the services that they need and in the referrals that they may need?

A. I have no experience. I only see Mr. Desmond as one military patient during my practice so, no.

Q. More generally, people that present with mental health difficulties, do you have the resources or are the resources available?

A. Yes, because we have 24-hours crisis team. In St. Martha's, we only have during the daytime. After hours, we don't have. And, also, we have a psychiatrist on call for emergencies 24/7.

Q. Just in your practice, and I appreciate I asked you earlier about occupational stress injuries and it wasn't a term that you were necessarily familiar with or that you used a lot,

but were you aware of the existence of an OSI clinic - an occupational stress injury ...

A. No.

Q. ... clinic - in Nova Scotia or in New Brunswick?

A. No. I didn't have a chance to send any of my patients to there.

Q. So, obviously, there was no discussion with Mr. Desmond about other forms of treatment such as the OSI clinic in Nova Scotia that he might be being considered for or that you might ... No.

A. No. I didn't ask.

Q. And he didn't volunteer that ...

A. No. He didn't tell me anything.

Q. I asked you earlier if you knew that he had had a case worker through Veterans Affairs Canada or VAC. You weren't familiar with that?

A. He didn't say anything. I didn't know.

Q. Okay. Had you known that he had a case manager through VAC, through Veterans Affairs, would that have been of any assistance to you? For example, would you have been able to contact that person?

A. If the patient allowed me to talk, I would have called

or I would ask my secretaries to talk to them.

Q. Okay.

A. If the patient gave us permission because ...

Q. You had mentioned, as well, that a person presenting like Lionel Desmond needed a multidisciplinary approach and we've talked about psychiatry and psychotherapy. In your experience with other PTSD patients, are there other services that patients with PTSD sometimes need beyond psychiatry and psychotherapy, like occupational therapy or other types or organizational things?

A. I didn't. Maybe they'll see their social worker.

Q. Right.

A. But other than that, I don't know.

Q. But had you been aware of the existence of a case manager from Veterans Affairs, with consent, you would have contacted that person to ...

A. First of all, I don't know if he has a case worker.

Q. Right.

A. Then, if he give me a permission, I may try. I would have.

Q. If you knew that that might help to facilitate other resources or access to other resources, with his consent, you

might have done that?

A. Yes, but I didn't know he has all these things.

Q. No, understood. Understood. Okay, thank you, Dr. Ranjini, those are the questions I have.

A. Thank you, sir, thank you.

Q. These other lawyers will have questions for you.

THE COURT: Mr. Anderson?

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

THE COURT: Thank you. Actually, I was going to normally call ... Ms. Ward?

MS. WARD: Yes, Your Honour.

THE COURT: Ms. Ward, what I'm going to ask you to do, we had some problems with that podium and the podium mic before, so if you could just move the podium back so that the microphone is kind of in front of you rather than beside you, I think you'll get better quality that way. Thank you.

CROSS-EXAMINATION BY MS. WARD

(10:58)

MS. WARD: Dr. Ranjini, my name is Lori Ward and I am a lawyer for the Government of Canada, so I represent the Canadian Armed Forces and Veterans Affairs and others. I just have a few

questions for you.

So if someone is presenting in the province and they need a specialist such as a psychiatrist, they can't just make an appointment with the psychiatrist. They would need a referral from someone like you, a general practitioner, a family doctor?

A. Yes.

Q. And you mentioned that if you were referring someone to the psychiatrist and you thought they needed psychotherapy as well, or other services, that would all go through St. Martha's and through that referral to the psychiatrist?

A. Yes.

Q. And so you mentioned that you thought Lionel Desmond needed a psychotherapist as well and you thought that that would be taken care of through your referral to Dr. Slayter.

A. Yes.

Q. Were you were of any, or are there any, psychotherapists who were practicing in Guysborough at the time?

A. I don't know.

Q. Those are my questions. Thank you.

A. Thank you.

THE COURT: Thank you. Mr. Macdonald?

MR. MACDONALD: No questions, Your Honour.

THE COURT: Thank you. Ms. Miller?

CROSS-EXAMINATION BY MS. MILLER

(11:00)

MS. MILLER: Good morning, Dr. Ranjini. My name is Tara Miller. I am the lawyer representing the personal representative Chantel Desmond on behalf of her mother, Brenda, and her niece, Aaliyah. I just have a couple of questions for you.

You ... I assume ... well, I'm going to ask you. Do you ever complete paperwork for firearm licenses for clients as a family doctor in a rural area?

A. No.

Q. You ... is that no?

A. No.

Q. No.

THE COURT: The answer is no.

MS. MILLER: Is that by choice or have you never had the occasion to complete that paperwork?

A. Because I have that much expertise on that part, I didn't do it. I don't have a chance to do it either.

Q. Okay, so you're not in a position to speak about

completing paperwork because you've not done it because you don't have the expertise to do that.

A. Yes.

Q. Okay. Thank you. You said something in response to Mr. Murray. You said, I did not know that Lionel Desmond was my patient in terms of being his family doctor.

A. When I was seeing him he is not under my care.

Q. Right.

A. So that is the first time I did see him ...

Q. Yes.

A. ... as a mental health issue.

Q. Right.

A. In the office.

Q. Yes.

A. So ...

Q. In early November.

A. Early November.

Q. And then you referred him back to Dr. Slayter. We know from the records that he was telling people that you were his family doctor. I appreciate your evidence earlier about how you were able to access records within the emergency room. You could see other hospital records in the EMR system. Is that ...

did I understand that correctly?

A. I could see it if it is available in there.

Q. Yeah. Okay. And if you had a patient who you referred to Mental Health in St. Martha's - which you said you've done. Those are the resources you have. Would you expect to get back ...

A. Oh, yes.

Q. ... reports?

A. Yes.

Q. And if a patient of yours was seen in the emergency room in St. Martha's for any reason and listed you as the family doctor would you expect to receive back ...

A. Yes. Yes.

Q. ... that emergency room record ...

A. Yes. Yes.

Q. ... in your office. And it would make its way into your file.

A. Yes.

Q. Okay. So I appreciate this is documents not in your file, but I'm going to ask for Exhibit 67 to be brought up. And just to help orient you, Dr. Ranjini, this is a Mental Health and Addictions detailed risk assessment that is found in the St.

Martha's file material. And I'm looking at page 7 of that exhibit. Have you seen this document before, Dr. Ranjini?

A. No, I didn't.

Q. You did not, no. We see in the first third of the page under "Family Doctor" you're listed as the family doctor.

A. Yes.

Q. And your ... would you typically have expected St. Martha's to forward this kind of an assessment to you if someone showed up in emergency there?

A. Yes.

Q. Okay.

A. But I don't ... we usually may not get these reports. We only get the specialist report. We don't get the psychologist or the Crisis Team reports.

Q. Oh, so if your patient shows up in emergency for mental health in St. Martha's, and this type of an assessment is completed, you don't get that kind of an assessment?

A. I didn't see this report, but I did see the emergency doctor's notes and those kind of stuff. But definitely, I didn't see this report at all.

Q. No, I appreciate you didn't see it, and it doesn't appear it was ever sent to you despite you being listed as the

family physician. But I guess my question is, generally speaking, when you have a patient - that is, your patient that you're following as a family doctor - they are seen in St. Martha's in the emergency room. You would expect to receive back an emergency room report of that visit for completeness of your file.

A. Yes.

Q. Okay. And in this case we understand from the evidence that this was a mental health risk assessment that was created as a result of an emergency room visit at St. Martha's. Have you ever seen a report like this come back to you from a client ... or a patient, rather?

A. I didn't see like that.

Q. Okay, so if you get back a report from St. Martha's from an emergency room for an emergency mental health visit it wouldn't include this level of detail.

A. I didn't see them at all. Nowadays we are getting the update from the Mental Health Unit recently, but at the time I didn't see this one at all.

Q. No, I appreciate you didn't see this specific report. I just wanted to understand what you ... if you knew he was your patient ...

A. Yeah.

Q. ... what you would have reasonably expected to receive back at that time.

A. Usually, the psychologist or social worker notes, we don't get it regular basis.

Q. Yes. Okay. Because if we look at page 10 of this report there is a section at Exhibit 67, page 10, that does anticipate distribution to ... if you see at the bottom it says on the screen, "Sent to", and there's a variety of different boxes that can be checked. We see youth ... child youth, family mental health, adult outpatients, inpatient mental health, addictions services. Then we see family physician. So we see that it anticipates it could be forwarded to a family doctor.

A. Yes.

Q. Yeah, but you didn't ...

A. No, I didn't.

Q. Your evidence is clear you didn't receive this despite being listed as the family doctor.

A. Yes.

Q. And there would be cases where you might not see it in any event because you just get the emergency report?

A. Yes, I get emergency department reports.

Q. Okay. Thank you, Dr. Ranjini.

A. So ... you're welcome.

Q. Those are my questions.

THE COURT: Mr. Rodgers?

CROSS-EXAMINATION BY MR. RODGERS

(11:07)

MR. RODGERS: Good morning, Dr. Ranjini.

A. Good morning.

Q. Just a couple of questions, Doctor. What is on mental health visits ... I guess more generally. In some ways, you're the front line in mental health conditions for people experiencing mental health crisis or wanting treatment. They come to you first in many cases. Would that be true?

A. Yes.

Q. And one of the reasons is if they need to see a specialist, if they feel they need to, or they need to, they have to go through you through the family doctor to be referred on.

A. Yes.

Q. The question, from your experience ... when somebody comes in to see you, you know, they feel they need some help,

some treatment. Is it often the case that they've already talked to friends and family and they relay that to you before they come in or, in your experience, is it more that they haven't or haven't been able to talk to friends and family?

A. Myself regarding the patient or ... sorry, I didn't get that.

Q. Sorry. In your experience, when a patient comes in with a mental health issue or something that they want to discuss, have they usually arrived having already talked to their friends and family about their condition and tried to get help ... you know, help or some ... just someone to talk to in that way or do you find that they've often not spoken to anyone else?

A. They have may talked to their family, may not.

Q. So it's ... there's no ...

A. So ...

Q. There's no real pattern to that?

A. Yes.

Q. Okay. What I really wanted to ask you, Dr. Ranjini, is your ... I guess your observations after the tragedy of January 3rd of 2017. You've been the doctor. You've been a member of the community in Guysborough for 15, 16 years now. Is

there anything you can share with us of your observations of the community of Lincolnville, Sunnyville, or the wider Guysborough community, and the impact that this tragedy has had?

A. Yes. It's a big tragedy for our community and, I'm sorry, I can't speak for everyone reaction to the tragedy. But I'm living in a small community. But this incident touched people in the ... people in the community in some way. And our ... the whole community was shocked and they are sad about this, what has ... what had happened to them, the incident, and nobody expected this to happen. So it is a big impact on everyone in the community.

(11:10)

Q. In the community. And, you know, I don't want to ask you about particular patients or the family. Of course the Desmond family and the Borden family are large families. So big parts of the community as well.

Well, thank you, Doctor. I thought that would be important for you to convey.

A. Yes.

Q. Certainly, you know, for ... to drive home in some ways the importance of the work we're doing and the efforts here. So I thank you for that.

A. You're welcome.

Q. Those are all the questions I had. Thank you.

THE COURT: Mr. Rogers?

MR. ROGERS: I have no questions. Thank you, Your Honour.

THE COURT: Thank you. Ms. MacGregor?

MS. MACGREGOR: Just have one question.

CROSS-EXAMINATION BY MS. MACGREGOR

(11:11)

MS. MACGREGOR: Dr. Ranjini, I just wanted to clarify one issue. You were asked a few moments ago about an October 2016 visit. I guess it was a crisis, mental health crisis note, and at that point you hadn't seen Cpl. Desmond in your clinic, had you? I know you had seen him in August 2015 in the emergency, but as a clinic patient, you hadn't seen him at that point?

A. No. I did see him on November 2nd.

Q. And sorry, your first clinic visit with him would have been ... well, I guess November 2, 2016, although it was ... it took place physically in the emergency. He had booked that, the clinic visit with you?

A. Yes. Yes.

Q. And prior to that you hadn't had any appointments with him in the clinic.

A. No.

Q. No. Okay. Those are my questions, Your Honour.

THE COURT: Okay. Thank you. Those are all the questions, Counsel? Mr. Murray, do you have anything?

MR. MURRAY: No re-direct, Your Honour.

THE COURT: Dr. Ranjini, thank you for your time. I know it took you some time to prepare and review your notes and takes some time away from your practice and your community today. We very much thank you for your time and ...

A. Thank you, Your Honour.

THE COURT: ... the opportunity to hear your evidence. Thank you.

A. Thank you, Your Honour.

THE COURT: Thank you. Counsel, I think we'll just allow Dr. Ranjini to withdraw. I'll just ... I would just ask you, Doctor. You probably do it anyway. Put your mask back on and ...

A. Yes, I have it.

THE COURT: ... and thank you.

A. Thank you so much.

THE COURT: Thank you. Thank you. You're free to go, Doctor, thank you.

WITNESS WITHDREW (11:13 HRS.)

THE COURT: Mr. Murray, we have Ms. Tofflemire this afternoon, do we?

MR. MURRAY: Yes, that's correct. I think it's set up right now already.

THE COURT: All right. So, Counsel, we're going to return for 1:30. I'm going to adjourn for the morning. I'm just going to ask everyone just to remain for a moment. Thank you.

COURT RECESSED (11:14 HRS.)

COURT RESUMED (13:30 HRS.)

THE COURT: Good afternoon.

COUNSEL: Good afternoon, Your Honour.

THE COURT: Good afternoon, Ms. Tofflemire.

MS. TOFFLEMIRE: Hello.

THE COURT: Hello. You can hear us all right, can you? All right. That's ...

MS. TOFFLEMIRE: Yes.

THE COURT: That's great. Thank you. Before you begin we would normally swear a witness, please.

NATASHA TOFFLEMIRE, affirmed, testified:

THE COURT: Mr. Russell?

DIRECT EXAMINATION

MR. RUSSELL: Good afternoon, Ms. Tofflemire.

A. Good afternoon.

Q. If at any point I cut out or you can't hear me just try to alert me and we'll maybe stop and get some direction on how to proceed.

A. Absolutely.

Q. So I guess I'll begin by asking your full name, if you could state that for the record.

A. My name is Natasha Marianne Tofflemire.

Q. And Ms. Tofflemire, I understand that you are a registered nurse?

A. Yes, that's correct.

Q. How long have you been a nurse?

A. I graduated from Dalhousie University in May 2015. So it's going on six years now.

Q. So for the period of six years, I guess, could you tell us a little bit about your employment history starting from

when you graduated until recently?

A. Absolutely. I began at the Abbie J. Lane, which is acute mental health. I was there for a new grad position for six months and then I went into ... I did a short-term on a medical unit, 8.4, and then went to the OSI to cover a maternity leave and then I proceeded to be ... then I went to Forensics for over two years, did one year in Gjoa Haven, Nunavut, in a remote posting, and then I've recently returned and I'm doing casual with ... it's Evergreen Home For Special Care. So it's older adults and kids with special needs, and I'm doing my nurse practitioner clinical in the Digby emerg currently.

Q. So is it fair to say that since you graduated, and over your six-year career, you've spent all of your ... the majority of your time as a nurse as it relates to mental health nursing?

A. The majority of my time as a registered nurse has been in mental health.

Q. So I understand for a brief period of time you were employed with the OSI clinic in Halifax.

A. Yes.

Q. From what dates were you employed there?

A. I began in February 2016 until the end of October 2016

covering a maternity leave.

Q. What was your role at the OSI clinic between February and October of 2016? What was your position, I guess, at the clinic?

A. I was ... we were two registered nurse and we were the intake and case management.

Q. So what sort of clients would you deal with at the OSI clinic? What backgrounds do they come from?

A. We receive ... what backgrounds? Mostly Veterans Affairs. So from ... releasing from the Canadian Armed Forces. I think we only had one that was from the RCMP at the time but most of our referrals came from Veterans Affairs.

Q. So as an intake nurse, I wonder if you could just take us through a little bit about what were your primary roles as an intake nurse between February and October of 2016 with the OSI clinic?

A. Absolutely. So what we'd do is we would receive the paperwork that came from Veterans Affairs and we would go through the paperwork, make sure that it was all appropriately filled out, follow up with the case manager to clarify any needs or specific needs that a veteran would have and what the OSI could provide, and from there if we proceeded we would contact

the veteran, discuss with them what they were looking for, and do a suicide risk assessment and then bring it to the team of clinicians, which were psychologists, social workers, an OT. And we had a psychiatrist on and off to discuss how we could help the veteran.

Q. So just ... you mentioned case manager. Case manager with what sort of entity are you referring to?

A. I would ... oh, I would contact the case manager in Veterans Affairs.

Q. All right, so at the time you were in that role of 2016 did you receive any sort of orientation or training as to the roles and obligations of an intake nurse at the OSI clinic?

A. It was very informal as training. We were still in the beginning of opening the OSI. I think they had only recently moved into the building that week or within that month and they were still writing out policies and processes. But I did get basic orientation with the manager at the time and shown the paperwork and proceeded from there.

Q. So we're going to hear a little bit more from another witness, but is it my understanding that the OSI clinic in Nova Scotia didn't sort of open its doors until a few months prior to February of 2016? I guess fall and winter of 2015.

A. Yes, that is correct, but they were working out of a temporary office as far as I know.

Q. And so your recollection is when ...

A. So ...

Q. When you started in February was when they moved to their current location in Halifax ... or Dartmouth, sorry.

A. Yes, in Burnside, and that's when we started receiving clients, patients in the facility for treatment.

Q. Do you recall in your period of time there how many sort of ... on average, maybe weekly or monthly, how many intake assessments you would process?

A. I don't recall exactly. At the beginning it may have been one or two a week and then by the end of it I was processing maybe three or four cases a day.

Q. We know now that ... and again, we're going to hear from another witness. But we know now that it's Veteran ... as it relates to military veterans, it's Veterans Affairs that makes the referral to the OSI clinic in Nova Scotia, but back in February to October could another OSI clinic, say from New Brunswick, make a referral directly to Nova Scotia?

A. From what I recall, they could make the referral, the paperwork, but we still had to follow up with the VAC case

manager because they had paperwork and their own specific Veterans Affairs OSI referral sheet that needed to be completed for us to proceed. Because they were the ... they managed the overall case of veterans.

Q. So even when you were involved, if another OSI clinic made a referral, or tried to make a referral directly to Nova Scotia, you still had to confirm with Veterans Affairs before you processed that referral?

A. That ... that is correct.

Q. Do you know the rationale for that? Or if it's something you can't speak to that's fine.

A. I believe it was for administrative purposes but that was beyond my scope and my role at the OSI.

Q. So as an intake nurse ... and I'm mindful of the fact you were there less than a year. Did you receive any sort of specialized training as it relates to operational stress injuries and, in particular, operational stress injuries as they relate to military veterans?

A. No, none of my training related to mental health and specialized mental health training was given by the OSI.

Q. And do you know ... in your time dealing with various patients from different backgrounds, whether it be a military

veteran or someone in the regular civilian population dealing with a mental health diagnosis ... whether it be depression, anxiety, PTSD. As a mental health nurse, is there a difference when you're encountering someone from the general population versus a military-based client?

(13:40)

A. Yes and no. The traumas can be different depending on their diagnosis, but PTSD would still follow the same treatment for any PTSD. Anxiety would still follow the same treatment for anxiety. Depression for depression. I think resources is what we ... when I was working at the OSI we had more resources to support veterans as opposed to what I see in the community.

Q. In terms of ... have you ever had an opportunity to operate in a capacity of an intake mental health nurse outside of the OSI clinic as it dealt with veterans? Did you ever perform that role elsewhere?

A. The only time I saw a veteran outside of the Operational Stress Injury clinic was in ... at the Abbie J. Lane. We did have one patient that was a veteran.

Q. But in your role ... have you ever been an intake nurse outside of ... a mental health intake nurse outside of the OSI clinic in Halifax?

A. No, not that role specifically.

Q. So I'm wondering if you could just take us a little bit in general through the intake process, how you've seen it in your time at the OSI clinic, back in 2016? Step by step, what is it that you do?

A. We would ... the clerks would receive the referrals via fax. They would place it in a bin for myself or the other triage nurse to go and get and we would alternate. I would take this. I would read through the documents. I would contact the VAC case manager to discuss, because the intake document or the referral document is very small and a lot of times needs are actually a lot bigger and can be better clarified if discussed as opposed to one-liners on a sheet.

And from there I would contact the veteran. I would go through their demographics and discuss, if they felt comfortable, what their needs were. And it was always an option to not to discuss it if they didn't feel comfortable. I would do a suicide risk assessment over the phone and then bring it ... once that was completed I would let them know that we'd be bringing it to the team to determine which clinician would be best suited for their treatment and that the clinician would follow up to book an appointment with them for them to come in

to the clinic.

Q. So I guess ultimately who would have the decision as to whether or not the veteran was going to actually enroll in the clinic. Was it the veteran's decision or did it have to meet with the approval of Veterans Affairs Canada?

A. Ultimately, any mental health treatment falls on the client. We can't force them to come. Even Veterans Affairs, they have the final say as to what they will fund or not fund, but the patient has to decide what they want and what they feel they need. And it's a discussion between the patient and the VAC case manager to find the most appropriate services.

Q. So your understanding is that there's a discussion that would take place outside of you between Veterans Affairs case manager and the veteran as to what it is they're looking for out of the OSI clinic in Nova Scotia?

A. Absolutely.

Q. And I understand that funding for the client for a military veteran is funded through Veterans Affairs Canada. Is that correct?

A. That is correct.

Q. So you mentioned a little bit about the documentation that you would receive as part of a referral. Typically, what

sort of documentations do you get when you get a referral from Veterans Affairs or from another OSI clinic at the time as it relates to a veteran?

A. Sometimes we only would receive just the OSI referral from Veterans Affairs. Other times we would have reports from community psychologists. Or if they had in-treatment elsewhere we may or may not have access to those documents, but we did not always have more than the direct referral sheet.

Q. And when you say the direct referral sheet I believe you said sometimes it would be pretty scant, I take it, as to the information you were given that would prompt you, then, to have to go back to the Veterans Affairs case manager?

A. That is correct. It was ...

Q. How ...

A. ... one page with their demographic and what they're looking for, tick boxes, and a little space to write at the bottom.

Q. So how often would you receive with the referral ... for example, how often would you receive medical records of the veteran from the Canadian Arms Forces? So if they were involved in the Canadian Arms Forces and they saw a psychologist and a psychiatrist there how often would you get that information as

part of the intake?

A. I personally never recall getting anything from their time within the Canadian Armed Forces. Most of it we received if they had seen a psychologist in the community afterwards.

Q. So in a scenario where it may be a veteran such as Lionel Desmond attended an OSI clinic in New Brunswick after ... post discharge from the military. Would you typically see the records the psychologist, the psychiatrist ... would you receive those reports from another OSI clinic? As part of the referral.

A. I don't recall receiving many referrals from other OSIs. I believe only one other one from Alberta and it was not standard to receive all of the documentation.

Q. So as a rule, when you received a referral, say from Veterans Affairs regarding a veteran, other than the ... you said the one-sheet referral with some tick boxes, did you as a rule have any sort of medical documentation of the veteran's history as part of that referral?

A. It was not a rule. We'd ... as long as we received the referral from Veterans Affairs, that's what we proceeded on.

Q. So I guess out of ten referrals how many would come in as a standard form versus how many would come in with a form plus some medical history attached to it?

A. I don't recall exactly. I would say 50 percent came in with only the referral sheet. Another 40 came in with maybe one or two supporting documents, and you would get the one that was extensive.

Q. What is the purpose behind you doing the intake referral? What is it you're trying to find out? Why do the intake referral, I guess? What's the purpose?

A. The purpose for having ... my understanding, the purpose of having a registered nurse doing the intake referral is once ... it's case management. So it's not just administrative, and you had to talk to the ... if it proceeded you had to talk to the veteran themselves and do a suicide risk assessment, which you need a licensed professional to do an understanding of the medical background behind the referral and then being able to bring that to the team of clinicians to determine a specific treatment for the veteran.

So my role was to oversee referrals that came in to us and that would be followed by the OSI and then to liaise between the team at the OSI and the veteran, the VAC case manager to discuss ongoing treatments and what other possibilities or needs that may have arisen.

Q. So at the intake stage is it important to you ... for

you to know a little bit of the medical history of the veteran as to what it is they might have been diagnosed with, what it is they may need going forward? Is it important there to know?

A. Basic information is important. We don't always have the diagnosis. Some of them don't come to us with a diagnosis, but we need basic information of what they are seeking treatment for and then they can get their diagnosis later. But we don't always ... we don't need the whole story to bring them into our clinic.

Q. Okay.

A. We need to know that they're willing, that VAC has approved, and that we can provide services that they're looking for.

(13:50)

Q. So I'm going to ask you about in particular Lionel Desmond, and if we look at Exhibit 147 ... this will come up on the screen for you. And I'm going to cycle between pages 3 and 4. You may even have these in hard copy in front of you, I believe, through your counsel. I just want to give you a chance to see that. Do you see that on your screen, Ms. Tofflemire?

EXHIBIT P-000147 - OPERATIONAL STRESS INJURY CLINIC MEDICAL CHART

A. Yes, I do. Yes.

Q. Do you recognize what this document is?

A. Yes, I recognize. It's an inter-OSI clinic referral.

Q. And up ...

A. From New Brunswick.

Q. And up at the top left it shows September 30th, 2016. Is that the date in which, I guess, Nova Scotia OSI would have received this referral?

A. I can't speak to that. Sometimes a fax came through, sometimes they didn't. And that was the clerks that dealt with that first portion.

Q. But as a rule, I guess, September 30th, 2016 ... when did you first ... this document first come to your attention?

A. When I would have triaged it would have ... which would have been on October 6th.

Q. Okay, so about a week later you would have triaged Lionel Desmond. Is that correct?

A. That is correct. According to my notes, yes.

Q. So before we get to that. So this particular document, as you indicated, comes from the OSI clinic in New Brunswick. It's from Dr. Mathieu Murgatroyd. It says: "Date sent September 30th, 2016." What did you understand that the

referral was for?

A. At the time the referral came through from the OSI that the client was transferring or had moved to Nova Scotia from New Brunswick and that he was looking into accessing services and they were looking for him to be connected to the OSI in Nova Scotia.

Q. And so if we turn to page 4, the next page, about three-quarters of the way down it says: "VAC case manager, Marie-Paule Doucette.

A. Mm-hmm.

Q. And did you understand that she was the case manager for Lionel Desmond?

A. Yes, that was my understanding.

Q. And again it says: "Reason for referral", as noted and did you understand that this reason for referral was filled out by Dr. Mathieu Murgatroyd, who was the psychologist at the New Brunswick OSI?

A. Yes, I did.

Q. And what do you see noted as the reason for referral?

A. For psychiatric followup at the Operational Stress Injury and that he'd be following a therapist in the community.

Q. When you received ...

A. So for him to access ...

Q. Go ahead.

A. ... psychiatry.

Q. And when you received this referral did you get a sense that, in fact, Lionel Desmond's referral to the OSI in Nova Scotia was supported by a treating psychologist in New Brunswick?

A. Based on the paperwork, it does look like it was supported, the transfer over to our OSI.

Q. If we could turn to page 5. Page 5 indicates a progress note May 9th of 2016, and it's signed by Dr. Njoku, a psychiatrist at the New Brunswick OSI clinic. This document, did this come as part of the referral for Lionel Desmond?

A. I don't recall.

Q. If you look at the top of the page again it says: "September 30th, 2016", and I understand you can't comment, I guess, on how faxes are received at the OSI clinic. And there's a barcode down at the bottom of page 5. It says: "Referral forms". And on the previous page, on page 4, there's an ... also a barcode. And page 3 has the same barcode. Does it appear as though this all came as one document?

A. It appears as it came as one document but I can't

speak to what those barcodes mean.

Q. So if you turn to page 6. Again, we have a progress note, Dr. Njoku, from New Brunswick OSI, January 27, 2016. Do you recall seeing this document?

A. I don't recall.

Q. If you turn to page 7 again it looks like ... on the top left, September 30th, 2016, it's a recommendation to the Ste. Anne's stabilization program in Quebec for Lionel Desmond. Do you recall whether or not Lionel Desmond had been referred to the clinic in Quebec on a previous occasion?

A. Not ... that wasn't within my scope to refer him to Quebec. That was before his discussion with the VAC case manager.

Q. But were you aware that Lionel Desmond ... when you were doing the intake for Lionel Desmond were you aware that he had spent time in Quebec at a residential program?

A. I don't recall if I was aware or not.

Q. And similarly, page 8 and page 9.

A. Actually, based on my notes, I was aware that he had recently done a stay in Ste. Anne's.

Q. Okay.

A. Yes.

Q. So we have similar documents, page 8, page 9, page 10, 11, all the way up to page 14, which are reports from Dr. Njoku out of OSI New Brunswick, along with a report from Dr. Murgatroyd. When you did the intake of Lionel Desmond do you know if you would have referred any documentation that would have maybe accompanied his referral?

A. Referred his documentation to who?

Q. So you would have received ... you indicated that you had received the fax coversheet with the recommendation on page 3.

A. Yes.

Q. And if pages ... and you said you received page 4.

A. Mm-hmm.

Q. If pages 5 through 14 had accompanied that referral document would you have reviewed those documents?

A. Yes.

Q. And it's to your recollection that you don't recall ever seeing those documents or you're not sure?

A. I just don't recall seeing the documents, but I saw ... based on my note, I saw the documents saying that he had done a time, a stay in Ste. Anne's and that he required psychiatric followup. And that's ... I called the case manager

to clarify.

Q. So we'll turn to that. So you are the one that reaches out to the case manager, and if we turn to page 2 of Exhibit 147 there appears to be a charted note here. Sort of a database entry. What is this that we're looking at?

A. This is my progress note based on the referral that I had received and me contacting the VAC case manager to discuss how we would be suited to help Mr. Desmond.

Q. So as a rule during your time as an intake nurse at the OSI clinic in Nova Scotia, as you were taking actions on a file would you always make progress notes?

A. On every ... any contact with the VAC case manager or with the client would have a recorded note.

Q. And what was the reason behind that?

A. Good documentation. It's to chart any communications, any plans, any questions, and what followup was needed. This is standard documentation in nursing.

(14:00)

Q. So I understand that at some point you received the referral and the recommendation from New Brunswick OSI, and then your entry indicates October 6, 2016.

Is that the date you contacted Veterans Affairs case

manager Marie-Paule Doucette?

A. Yes, that is correct.

Q. And what was your purpose of calling her on that particular date?

A. At the time, we still needed a referral from Veterans Affairs. We didn't have the policies in place to receive direct inter-OSI referrals, and Veterans Affairs was still managing all veterans and they had the direct communication with the veteran. So calling Mary-Paule Doucette at that time was to clarify what his needs were, that we needed the intake - the OSI referral sheet - from Veterans Affairs to proceed.

Q. So at this point is it fair to say that the information you had was that Lionel Desmond was being recommended to Nova Scotia OSI by treating psychiatrist and psychologist from New Brunswick?

A. Yes, we still needed approval through Veterans Affairs.

Q. All right. So your purpose of calling Ms. Doucette is to confirm whether or not she is giving you approval from Veterans Affairs to proceed with the referral?

A. And also to clarify what his needs were where he was situated outside of our local community and he was seeing a

psychologist in his own home community, is to clarify what his needs are and what we could provide him with at the OSI.

Q. So if you could tell us a little bit about the ... do you recall approximately how long the conversation was between you and Ms. Doucette on October 6th?

A. I do not recall exactly how long it was.

Q. And do you recall what you discussed regarding what Lionel Desmond's needs were?

A. Yes. I had contacted Mary-Paule Doucette and at that time, Mr. Desmond had decided to proceed with a community psychologist and he would require psychiatry follow-up, but she felt at the time that having him settled in his community with a regular psychologist was the more pressing issue.

Q. So if you could tell me a little bit about that. So you said she indicated to you that she felt having a psychologist in his own community was a pressing issue, is that correct?

A. That is correct.

Q. What sort of discussion did you have regarding psychiatry and the original referral, I guess, from New Brunswick that said psychiatry with the OSI clinic in Nova Scotia? Did you discuss that with Ms. Doucette?

A. I did discuss it. Our psychiatry at the time was still very intermittent and booking several months ahead. I do not recall specifically what the policy or if there even was a policy around having a family doctor, but I recall that it ... the preference was that they had a family doctor if being followed up by psychiatry with the OSI.

Q. So just so I get it right. So the OSI clinic in Nova Scotia, it was unclear, I guess, how quickly a veteran referral would get to see a psychiatrist at the OSI clinic?

A. That's correct.

Q. Did you understand that there might have been some delays at that time?

A. Yes, there would have been.

Q. What sort of delays were there to see a psychiatrist at the OSI clinic in Nova Scotia? How long of a delay, do you recall?

A. Months. When I left we were booking I think two months ahead and we only had a part-time psychiatrist for medication management. Psychiatric medication management only.

Q. And so when you say at the time you had a part-time psychiatrist, do I take it it was a psychiatrist that wasn't there five days a week?

A. No, she was not.

Q. So was she the only psychiatrist that was a available at this stage? I guess, during the time Lionel Desmond's referral came in, the OSI Nova Scotia only had a part-time psychiatrist, is that what you recall?

A. That's what I recall.

Q. And there was at least a two-month wait period?

A. That is correct.

Q. So did this factor into the discussion you had with Ms. Doucette? Because we know New Brunswick OSI wanted Lionel Desmond to have a psychiatrist from the Nova Scotia OSI. The fact that there was a delay and only a part-time psychiatrist in Nova Scotia, did this factor in your discussion with Ms. Doucette as to what was going to happen with Lionel Desmond?

A. It was likely a factor but it wasn't the main factor. We needed the referral. And at that time, from my understanding is she would follow-up at a later date if he hadn't found services in his community.

Q. So the other aspect ... and I'll come back to that. The other aspect that I wanted to explore was the suggestion that he may have needed or there was some discussion that it would be preferred that he would have a family doctor. What was

that all about?

A. I don't recall the exact reasoning for needing a family doctor in order to see psychiatry. But I know that I recall that it was ... not a require- ... they wanted veterans to have a family doctor followed by psychiatry at the OSI.

Q. And if that was something that came from the OSI? Just so I understand. So the OSI wanted or preferred that a veteran that was going to be followed up by psychiatry, have a family doctor?

A. I don't recall if it was from the OSI or from our part-time psychiatrist at the time.

Q. But someone, whether it was the psychiatrist or OSI, said if we have a veteran that's going to be followed by psychiatry we'd prefer if they have a family doctor?

A. That is correct.

Q. Now was that something that was ... I don't want to say mandatory, I guess, but was it if you didn't have a family doctor you weren't going to get psychiatry at the OSI?

A. I don't recall. I don't recall if that was an absolute.

Q. But you do recall there was some sort of, whether it was a prerequisite or a preferred method that a veteran have a

family doctor if they were going to access OSI psychiatry?

A. That is correct.

Q. Were you part of those discussions as to sort of you can tell us why that was the case?

A. I was not a part of those discussions.

Q. In your note on this page, page 2, you indicated starting at the end of the ... I guess I'll just read the whole note and then I'll break pieces down. It says:

> Called back case manager Marie-Paule Doucette (and there's a phone number listed) to discuss referral of client by New Brunswick OSI. Case manager voiced that the client decided to proceed with the community therapist as he lives in Antigonish, but she will do a referral to the clinic for psychiatry as client has recently done an in-patient at Ste. Anne and requires psychiatry followup. She will verify if he has a family doctor before proceeding with the referral. File will be placed on hold until then.

So I guess my question is she will do a referral to the

clinic for psychiatry. So is it my understanding, because you made the note, is it my understanding that this conversation in October left off that you understood that Marie-Paule Doucette was going to refer Lionel Desmond for psychiatry at the Nova Scotia OSI?

A. After she had followed up with him. It was my understanding, because we still needed a Veterans Affairs referral form, that she would follow up if she felt that was needed with us with a referral from Veterans Affairs for psychiatry.

Q. Did you understand who she was going to follow up with? Did she indicate?

A. My understanding is with Lionel Desmond to see if he had a family doctor and the rest is she could probably speak better as to who she would follow up with.

(14:10)

Q. And that's my next thing that I'm sort of struggling with a little bit is because it seems clear that she's going to do a referral to the clinic for psychiatry, subject to following up with Lionel Desmond, and then that she will verify if he has a family doctor before proceeding with the referral.

So am I interpreting this correctly that before referral

was going to proceed there had to be some verification of whether or not he had a family doctor? Was that the hangup?

A. It was more, it was whether he needed psychiatry immediately, whether he had a family doctor, or whether he could be followed by psychiatry in his own community.

Q. And just maybe I'm missing it and I keep it pressing it, but what was the relevance of whether or not a veteran had a family doctor or not? There was from your standpoint there's a referral that says he needs services. There's an assessment of some sort done. Whether or not he has a family doctor seems sort of inconsequential to whether he needs the service. I'm just wondering why that factored into the equation.

A. I don't recall the exact reasoning for needing a family doctor but it was one of the preferred requirements at the time.

Q. And so you indicated that "file will be placed on hold until then". What do you mean by the file is placed on hold?

A. That I would take all the documents, the note I had made, we'd make a folder and we'd put the folder in a cabinet and wait for further instructions from Veterans Affairs.

Q. So ... just so I understand, so the OSI was just going to put the file sort of away until you heard back from Veterans

Affairs?

A. That's correct.

Q. And in the ordinary course of things, would anyone from the OSI, whether it was you in an intake capacity, if you hadn't heard back would you take that sort of off the shelf and re-contact that agency and say, Look, haven't heard from you, what's going on?

A. Not if anything ... at that point, the file was closed and he wasn't going to be followed by the OSI until she decided to refer him for any services. So at that point - and I had only been there six months - there wasn't enough timeframe for us to start going back at that point to see where referrals that were put on hold, where they had ended up.

Q. And I appreciate you're sort of the middle person I guess in this scenario, you have two different people that you've gotten information from, New Brunswick OSI and Veterans Affairs Canada, you're in the middle doing the intake. Where you left off at the end of this conversation, did you understand that New Brunswick OSI wanted Lionel Desmond to attend Nova Scotia OSI?

A. From my understanding is that New Brunswick OSI wanted Lionel Desmond followed up by a clinician. It wasn't specific

to Nova Scotia OSI at that time. Whatever services he could access that he needed, whether it was in the community or with us, as long as he was followed, was the most important factor.

Q. So after October 6th, do you ever hear from Marie-Paule Doucette again?

A. I have no notes recording it and I would have ... if there would have been another referral, any further contact I would have made a note.

Q. And the disclosure that everyone has been provided with out of Nova Scotia OSI, you have it in front of you, it totals 14 pages, it has the referral and it has some New Brunswick documents that I had referred to and your note of your conversation, are you aware of whether or not Veterans Affairs, whether it's Marie-Paule Doucette or anyone else, ever had any further contact with Nova Scotia OSI regarding Lionel Desmond?

A. I'm not aware that they had any further contact with me. I can't speak to other clinicians.

Q. So you as the ...

A. But the paperwork, if they would have had contact with any other clinician, the paperwork would have been there to support further contact.

Q. So you, as the intake nurse, charged with the Lionel

Desmond referral had one conversation with Marie-Paule Doucette and that was documented as 9 o'clock, October 6, 2016?

A. That is correct.

Q. You indicated the file would be placed on hold. Were you expecting her to sort of ... Marie-Paule Doucette to give you some sort of answer or update as to what was decided?

A. My understanding is that she would follow up with the veteran and that he had a preference of staying in his community. At that point, that file was closed. It wasn't uncommon for us to receive referrals from Veterans Affairs and then veterans decide, especially in the Sydney area, to not proceed with coming to the OSI in Burnside, a five-hour drive away. So for us to receive a referral, call Veterans Affairs and say actually they found a community psychologist that they'll follow up with, I would chart that, close the file and that would be the end.

Q. So I guess you understood that any referral of Lionel Desmond to the Nova Scotia OSI, the fate of that referral rested with Veterans Affairs Canada?

A. That is correct. And with the veteran himself if he decided to proceed ...

Q. Yes.

A. ... with coming to see us or not, yes. Yes.

Q. Do you typically get veterans at the referral stage reaching out to the OSI clinic in Nova Scotia or is it usually directed through Veterans Affairs Canada?

A. Usually through Veterans Affairs.

Q. So is it fair to say it would be unlikely that Lionel Desmond would call you up and say, What's going on with my referral?

A. I've never had contact from any clients saying I'm waiting on a referral. They would have called their veteran ... their case manager at Veterans Affairs directly and asked about it. I've never personally received any phone calls from veterans ...

Q. If we ...

A. ... unless they were already a client seeing one of our clinicians and then that's different. They had already went through the intake, I had already contacted them, spoke with them, and I was their liaison within the clinic.

Q. Okay. I'm going to refer you to, it's Exhibit 244, page 42. So just before we get into the contents of this document, I wonder if you could tell us do you have any ... do you recall ever speaking to Lionel Desmond regarding his

referral to the OSI clinic in Nova Scotia?

A. I do not recall. I have never spoken to Lionel Desmond.

Q. So I just want to make sure what your evidence is. Is it you maybe don't recall that you spoke to him or you never spoke to Lionel Desmond?

A. I never had contact with Lionel Desmond. There would have been a note in his file saying that I had contacted him or that he had contacted me and what the content of our discussion was and what the plan was going forward. I had never had any contact with Lionel Desmond.

Q. Okay. And you indicated that normally in the ordinary course if you did, you certainly would have documented much like you documented the phone call with Ms. Doucette?

A. Yes, that's correct.

Q. So I appreciate page 42 of this particular exhibit is not your report, you've seen it. What this is, it's a running log that Dr. Murgatroyd kept of his work on Lionel Desmond's file and each day if he had any work on the file he would note it up.

So it indicates October 18, 2016 at 9 a.m., he indicates that he spoke with Nurse Natasha. Do you recall having a

conversation with Dr. Murgatroyd regarding a Lionel Desmond referral on October 18th?

A. I don't. I don't recall speaking to Dr. Murgatroyd, no.

Q. Is it possible that you might have spoken to Dr. Murgatroyd and you just don't remember?

A. Absolutely.

(14:20)

Q. I'm just going to ask you a little bit about that. He notes in his report, he said:

> The writer spoke to OSI Nurse Natasha, who confirmed she contacted Mr. Desmond to complete a triage. She indicated that at this time Mr. Desmond has a therapist in the community and that he would also be connected for psychiatric services in the community.

Would you have relayed that information to Dr. Murgatroyd about, one, I guess, speaking to Lionel Desmond?

A. If I had spoken to Lionel Desmond I would have relayed this, but I think this was a miscommunication between Dr. Murgatroyd and I.

The last sentence where Mr. Desmond is going to be followed in the community is correct. I'm wondering if he understood I had spoken to Mary-Paule Doucette and that this was the plan going ahead, as opposed to him understanding that I had spoken to Lionel Desmond himself, where my contact was only with the Veterans Affairs case manager Mary-Paule Doucette.

Q. And I appreciate it's his note. He says sort of twofold, he said ... regarding the community. He said: "Mr. Desmond has a therapist in the community," which I believe you confirmed that Ms. Doucette had told you in your October 6th conversation?

A. Correct.

Q. And then he says: "He would also be connected for psychiatric services in the community." He says it's sort of it's going to happen; he's going to have a psychiatrist or psychiatric services in the community.

But I just want to contrast that with your call to Ms. Doucette on October 6th. Was it set in stone that psychiatry was now going to be a community aspect or, where you left off in October 6th with Ms. Doucette, it wasn't overly clear yet?

A. It wasn't ... on October 6th it wasn't overly clear yet. The preference would have been in the community but that

was still left open.

Q. And back to that call with Ms. Doucette. Again, that discussion, why was the preference that he have a psychiatrist in the community and not with Nova Scotia OSI?

A. Because it's a five hour journey from ... or Antigonish, it's maybe three and a bit. But there and back it's a long commute and a lot of veterans that were in the Sydney area did not want to come in for a 40-minute appointment and do many hours of driving when they could access services in the community.

Q. So did you know that this was an issue for Lionel Desmond when you spoke to Ms. Doucette on October 6th? That he didn't want to do the drive?

A. This was an issue for many veterans in that community.

Q. So in your conversation with Ms. Doucette, did she reveal to you who this therapist was going to be in the community? Not the psychiatrist but the therapist?

A. No. No.

Q. Did she give you any indication as to where this therapist would be based out of?

A. No specific indications, just that he had a community therapist.

Q. Did she indicate what the qualifications of this therapist was ... or were?

A. No.

Q. Did she indicate why she felt this community therapist was suitable for Lionel Desmond's purposes?

A. That ... no, she did not and that is beyond what we would be doing. We wouldn't be verifying Veterans Affairs case management or appropriateness of other clinicians' ability to treat patients. We are self-governed bodies; therefore, you are supposed to know if you're able to treat a patient or not based on your qualifications.

Q. So did you have ... was there ever ... I guess I'll rephrase it. Was there ever any discussion with you as the intake nurse, Ms. Doucette as the decision-making body regarding Lionel Desmond's referral in consultation with him, whether or not the community treatment plan, which involved a therapist at that point, an unknown therapist, and potentially a psychiatrist, whether or not that was in Lionel Desmond's best interests and consistent with what New Brunswick OSI was saying?

A. No, that would have been beyond my scope to go and assess a plan of another clinician in the community, or for ... to assess veterans' case managers effectiveness or

qualifications to do their jobs.

Q. So is it fair to say that at the intake stage, when you were in the role of intake nurse, that regardless of the viability or suitability whether it was going to be appropriate, fine, or terrible, it's either a yes or no? Veterans Affairs is either going to refer them to you or they're not?

A. We would have the say if they were coming to us for appropriateness based on what services we can provide, but if they're going out into the community, no, we do not assess outside therapy.

Q. Later on on the same page, 42, and I appreciate this is Dr. Murgatroyd's note but there's a series of questions I'd like to ask from your perspective.

A. Mm-hmm.

Q. I'll read the entire note. He says: "Writer had a brief chat with Mr. Desmond." This appears to be an hour after his conversation with you. Murgatroyd's conversation with you.

> Writer had a brief chat with Mr. Desmond.
> He said he is in the process of being assigned a family doctor. He is taking his medication as prescribed. He still reports having nightmares. His priorities remain on

his family and he continues to look around to buy a house or property in the area. He continues to engage in activities with his daughter, for example, going horseback riding with her. He said his in-laws are still out West.

This is the particular part:

Mr. Desmond confirmed that the OSIC in Halifax contacted him and that at this time he would prefer accessing community resources than have to travel to Halifax. He does not yet have a local therapist but this will be discussed with his case manager once she gets back from her vacation. He will also be looking at getting connected to psychiatry in Antigonish.

So I guess again we have a second indication from Dr. Murgatroyd, this time from not you saying ... according to Dr. Murgatroyd that you spoke to Desmond, but that Mr. Desmond says he heard from someone at the OSIC in Halifax.

What's the OSIC in Halifax?

A. Oh, Operational Stress Injury Clinic.

Q. So again, this is the second time Murgatroyd is noting that Desmond is now saying he spoke to someone in Halifax OSI. To your knowledge, did anyone ever speak to Lionel Desmond from the Halifax OSI.

A. Not to my knowledge.

Q. Is there a scenario where it's possible that he could have spoke to someone other than the intake nurse?

A. I cannot see it happening because any phone calls that would have came, even if he would have called the clinic, they would have directed him to either myself or the other intake nurse. And if we would have proceeded with any kind of assessment or triage, we have a full form that would have shown up for any client that we do an intake or an assessment on. And there would have again been on top of that a progress note documenting any communication with the client.

Q. And the second part, Dr. Murgatroyd relays that Lionel Desmond on this date tells him that he does not yet have a local therapist. Is that the opposite ... is it fair to say the opposite of what Ms. Doucette told you on October 6th?

A. It was my understanding from Mrs. Doucette that he already had a community psychologist and that the psychiatry was still being discussed.

Q. Do you recall in your conversation with Ms. Doucette if there was any indication as to whether or not Lionel Desmond knew on October 6th, I have a therapist and this is who it is?

A. I'm sorry, the heat just kicked in so I didn't hear the end of that question.

Q. In your conversation with Ms. Doucette on October 6th, was there ever any indication as to whether or not she ... did she disclose to you that she told Lionel Desmond about the therapist in the community and who it was?

A. No, she did not disclose any of that information to me.

(14:30)

Q. So outside of your conversation with Dr. Murgatroyd on October 18th of 2016 where you relay the information from Doucette, do you have any further conversations or followup with the OSI clinic in New Brunswick?

A. Not ... no, not that I recall.

Q. And after that call, I guess, October 18th, 2016 where you update Dr. Murgatroyd, is there ever any sort of activity on Lionel Desmond's file as it relates to Nova Scotia OSI, or is that the end of it?

A. That's the end of it and I think I only ... after that

I was only there another week and a bit. So if there was any additional activity it would have been on another progress note or an intake form or a referral form elsewhere.

Q. So I understand when you said you were only there for another week and a bit. So you left about a week after this?

A. I left at the end of October, correct.

Q. If I can have just one moment, Your Honour.

THE COURT: Yes.

MR. RUSSELL: No further questions for Ms. Tofflemire, Your Honour.

THE COURT: Thank you. Ms. Ward? Okay. Ms. Grant?

MS. GRANT: Thank you, Your Honour.

CROSS-EXAMINATION BY MS. GRANT

(14:32)

MS. GRANT: Can you hear me okay, Ms. Tofflemire?

A. Yes.

Q. Hi.

A. Yes.

Q. My name is Melissa Grant and I'm counsel for the Government of Canada representing various Federal entities like Canadian Armed Forces and VAC. Thank you for your answers

today. Just a question that goes back to some of the things my friend was asking you earlier about a family physician, and we heard evidence this morning from Dr. Ranjini who was potentially a family physician or someone that Mr. Desmond had seen in Guysborough and she explained that in order to see a psychiatrist in the community you needed a referral from a family physician.

So I would just suggest to you that perhaps that might be the reason why Ms. Doucette was waiting to follow up with Mr. Desmond on that point. Is ... do you have any comment on that in terms of how that process works in the community, that you need a referral from a family physician before you can access a specialist like a psychiatrist?

A. I can't speak to if that was the exact reasoning for the policy at that time. I do know that where I'm currently working in the emergency we can also do direct referrals to psychiatry from the emergency room for patients that do not have family doctors. So I can't speak to if that was the reasoning behind it at the time or not.

Q. Okay. And in this case ... and I guess for your benefit in terms of information, Mr. Desmond had seen a psychiatrist in the emergency room but then was seeing a family

physician who then decided to make that referral.

A. Mm-hmm.

Q. In terms of that structure, would it make some sense to you that if somebody had a psychiatrist or was in the process of obtaining a psychiatrist for followup in the community that it wouldn't make sense to have a second psychiatrist, then, at an OSI clinic three hours away?

A. Absolutely that would make sense. On top of dual services and accessing two of the same professions, on top of that you have the re-experiencing your trauma. As a mental health patient, you don't want to have to go and tell your story everywhere in one spot and then have to re-tell it. Because as we see, either with all of the documentation from New Brunswick they would still have to come back and redevelop that relationship with a new clinician and re-experience their traumas.

Q. Thank you. And did you get any sense from Ms. Doucette that VAC would, in any way, deny a referral if a referral was made to your OSI clinic?

A. No, no, that is not ... the sense that I got at the time is that there was still decisions being made between the veteran and Veterans Affairs, the case manager.

Q. And just one point about the clinic. I think you had said earlier that maybe a typical appointment would be about 40 minutes or so.

A. Mm-hmm.

Q. Just so that we're ...

A. Yes, yeah.

Q. Okay. Thank you. Just so that we're aware, these services are on an outpatient basis, correct? They're not an inpatient service.

A. Yes, that's correct. It's outpatient.

Q. Thank you very much. Those are my questions.

A. Thank you.

THE COURT: Mr. Anderson?

MR. ANDERSON: No questions, Your Honour.

THE COURT: Mr. Macdonald?

MR. MACDONALD: No questions, Your Honour.

THE COURT: Ms. Miller?

MS. MILLER: No questions, Your Honour.

THE COURT: Mr. Rodgers?

MR. RODGERS: No questions, Your Honour.

THE COURT: Mr. Rogers?

CROSS-EXAMINATION BY MR. ROGERS

(14:36)

MR. ROGERS: Hi, Natasha. As you know, I'm Rory Rogers. I'm counsel for the Nova Scotia Health Authority. Just a few questions for you.

You flagged for the Inquiry that the clientele for the Nova Scotia OSI clinic would come from two sources: from the RCMP and Veterans Affairs Canada. Is that correct?

A. That is correct.

Q. And ... but was your primary experience in dealing with patients or clients those that came from Veterans Affairs, former Forces members?

A. Yes, that is correct.

Q. And then you indicated in response to one of the questions that Mr. Russell put to you was that ... my notes say you said that VAC decides whether they will fund or not fund. I know we'll have some senior personnel from the OSI clinic testifying later this week, but did you have any understanding as to how the NSHA and VAC worked together in terms of who was running the clinic and who was funding it?

A. My understanding is that we were both under NSHA and Veterans Affairs and that funding and support for the treatment

came from Veterans Affairs but we were under NSHA policies.

Q. And so ...

A. But I think management would be able to speak better to the fine details of this.

Q. And then in terms of getting authorization to deal with any veteran you, to your understanding, needed authority, needed approval from a Veterans Affairs case manager before that referral could proceed. Is that your understanding?

A. My understanding is that the referrals at that time had to come through Veterans Affairs or the RCMP, and even ... we didn't have the policies. And it wasn't that we couldn't take inter-clinic referrals. It's that the policies weren't set in place yet and that it was just as easy to have VAC involved in the process.

Q. Okay. You were also asked some questions about what records would typically accompany a referral and you indicated that it could run the gamut from the one-page referral from Veterans Affairs to a more extensive set of documents. In your role and your capacity did you, on occasion, seek additional records from either the VAC case manager or another source?

A. I would usually go to the VAC case manager for any additional documentation that we need. If they were accepted

into our clinic and some of the clinicians wanted background information I would go to the VAC case manager, or sometimes the clinicians would do it themselves, to see if we had any predated reports from any other clinicians.

Q. Why would you go to the VAC case manager to secure those informations? Or why would another clinician within the OSI clinic go to the VAC case manager to secure those materials?

A. Because they had access to it.

Q. Okay.

A. We don't ... we didn't have access to any other notes from outside clinicians or from their time in the military or any other treatment.

Q. You made reference to therapy being available through the OSI clinic and there was also a number of questions put to you about therapy that might be available in the community. And you commented on the fact that a number of the veterans who were living outside of the Halifax/Dartmouth area would choose to get some of those services, the psychology or the therapy services, in their local community rather than travel to the Halifax/Dartmouth area.

(14:40)

Did you see similar situations during the time you were

there where a veteran who was getting some services at the OSI clinic ... where they elected to secure some of those services through a therapist outside the OSI clinic?

A. Yes, and particularly in the Cape Breton Region we would get referrals and they would opt out due to the distance and seek treatment in the community, and we also had times that they would just come for psychiatry because they already had a community clinician, a psychologist, that they were seeing on the outside. Or they would come for social work for help with accessing different services, but they would still have an outside clinician following up on psychotherapy.

Q. Okay. And the types of clinicians that were available during the time you were at the OSI clinic in Burnside, what sort of health professionals were available for therapy or for treatment?

A. We had one psychologist, two social workers, two registered nurses - we did mostly the intake and case management - and at the end we had an occupational therapist.

Q. Okay. And in the community were those services being used by some veterans as well outside of the OSI context? So would people have been going ... getting psychiatric services through the OSI clinic but electing to get some of those other

therapy-type services you just described in the community?

A. It depends what ... so if they were seeing our psychologist they ... in the OSI, they wouldn't be seeing another psychologist on the outside. But let's say they were seeing occupational therapy with the OSI. They could still have a psychologist on the outside as long as it wasn't the two same services that they were using internally and in the community.

Q. Okay. Thanks. And, Natasha, lastly, during the time you were at the OSI clinic did it serve a function for emergency mental health matters?

A. No, we were not an emergency services. If they ... if any patients, clients called up with emergency needs we would refer them to 9-1-1, Mobile Crisis, or to the emergency room. We were an outpatient clinic.

Q. Thank you.

THE COURT: Ms. MacGregor?

MS. MACGREGOR: No questions, Your Honour.

THE COURT: Thank you. Mr. Russell?

MR. RUSSELL: I have nothing in re-direct, Your Honour.

EXAMINATION BY THE COURT

(14:43)

THE COURT: Ms. Tofflemire, just a couple questions, and I may have missed it. But was there a maximum caseload at the time that you were at the OSI Clinic in Dartmouth? Like, was there a max ...

A. For the individual ... a maximum for the clinicians?

Q. Yes.

A. I could not speak to what their ... I can't speak to what their maximum caseload was at the time.

Q. All right. Thank you. When your ... the note from the conversation that you had with Case Manager, Ms. Doucette, when it said that she was going to verify if he had a family doctor and that the file would be placed on hold till then, is there a difference between a file being placed on hold and it being closed?

A. At that time it was just a different drawer in a filing cabinet.

Q. Okay, but ... I appreciate that. But was it a different drawer with the same outcome? Did something that was ... something that was put on hold, was it effectively closed until it was reopened or was it well and truly on hold because

there was more work that was anticipated to be done and was not yet closed?

A. While I was there we never actually closed any case files or any recommendations that came to us. Even when the recommendation came through and they said, No, we ... they changed their mind and they're going to be seen in the community it was still just put on hold in case they changed their mind and were still under the services they can always be re-referred. So we never closed a case.

Q. Per se. Right. So effectively, if the case manager was going to follow up with verification as to whether or not Cpl. Desmond had a family doctor and was still interested in a referral for psychiatric services in the community that would be well and truly a hold-type scenario. Correct?

A. Yes.

Q. Correct? Thank you.

A. Yes.

Q. When you spoke with the case manager ... and I appreciate that there were ... there had been a number of things discussed. Would you have had a discussion with the case manager in relation to whether or not Cpl. Desmond was in need of services? I'm going to use the word "right away" as opposed

to, Don't worry about it, we can let this go for a couple months. Or anything in between. I don't mean to suggest one or the other, but was there a case ... as there any discussion that touched on the issue of urgency or the need for services for Cpl. Desmond at that time?

A. Yes. From my recollection, it was that he would need ... he would need services, and not months down the road, but that they would be followed in the community. So there was ... I wouldn't call it an urgency. There was a need for followup, of prompt followup, but it wasn't an emergency need or an urgent need to come and be seen by the OSI. Which again, then, if it was an emergency need they ... he should have been followed up with us.

Q. I see. So ... and perhaps you did ... you may have picked the right word when you used the word, There was need for some prompt attention to the file. Would that be ...

A. Yes, correct.

Q. ... a fair way to characterize it? And ...

A. Yes, Your Honour.

Q. And the case manager had indicated to you that they were going to take on the issue of whether or not there was a family doctor available and they would presumably get back to

you at some point to have a further discussion or confirm with you. Correct?

A. Yes, Your Honour.

Q. All right.

A. Or if they required our services, then they would follow up with you. Me.

Q. That's right. The case manager could have had a discussion with Cpl. Desmond who said, Well, I have a family doctor but, you know, I found a psychiatrist in the community and I don't need the services provided through OSI Nova Scotia, so thank you very much for your time. In which case that would have been ...

A. Yes.

Q. ... the end of it ... for you as well. But assuming that he was interested in having psychiatric services, still interested, so that's not one of the issues you have to determine. They still needed to determine whether or not he had a family doctor, and he was not likely to get a referral into the clinic unless he had a family doctor. Would that be correct?

A. That was my understanding, Your Honour.

Q. Yes. Okay. Okay. Thank you, then.

Thank you, Ms. Tofflemire. I appreciate your time, and certainly, I know you put in some time to prepare for today and read some notes and participated in some kind of dry-run conversations. So again, thank you very much for your time. The information is important for us here. Thank you.

A. Thank you very much.

Q. Thank you.

WITNESS WITHDREW (14:50 HRS.)

THE COURT: I take it that that's the evidence for the afternoon, gentlemen?

MR. RUSSELL: It is, Your Honour.

THE COURT: All right. Thank you, and tomorrow morning at 9:30 we're going to begin with which witness?

MR. RUSSELL: Dr. Khakpour? It is Dr. Khakpour, Your Honour.

THE COURT: Dr. Khakpour?

MR. RUSSELL: And then Dr. Harnish will be here in person.

THE COURT: Dr. Harnish will be here in the afternoon ...

MR. RUSSELL: Yes.

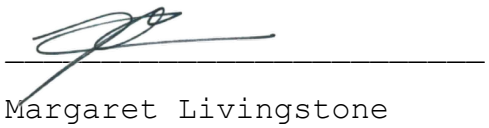
THE COURT: ... is my understanding. All right. Thank you. All right. There's no ... nothing in particular to talk

about, then, Counsel. Thank you for your time and we'll see you tomorrow morning at 9:30.

COURT CLOSED (14:51 hrs.)

CERTIFICATE OF COURT TRANSCRIBER

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



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