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 10, 2021

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

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

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

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

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

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

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

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

INDEX

EXHIBIT LIST

March 10, 2021

COURT OPENED (09:29 HRS.)

THE COURT: Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Mr. Russell?

MR. RUSSELL: Yes, Your Honour. Good morning.

THE COURT: Good morning.

MR. RUSSELL: I'll be conducting the examination of Dr. Khakpour this morning.

THE COURT: Okay. Good morning, Dr. Khakpour. How are you today?

DR. KHAKPOUR: Thank you very much, Your Honour. Thank you. Good morning.

THE COURT: Thank you.

DR. KHAKPOUR: I'm not bad. Thank you.

THE COURT: All right, Dr. Khakpour, before we being. We would normally swear a witness or ask the witness whether or not they're prepared to make a solemn affirmation ... we'll give you some options in a moment here.

DR. ALI KHAKPOUR, sworn, testified:

THE COURT: Mr. Russell?

DIRECT EXAMINATION

MR. RUSSELL: Good morning, Dr. Khakpour.

A. Good morning, Mr. Russell.

Q. And, Doctor, I wonder if we could begin just by getting you to state your full name for the Court, please?

A. Yeah. My first name is Ali, A-L-I. My last name is kaj-poor, we would pronounce it. Yeah, Khakpour is K-H-A-K-P-O-U-R.

Q. And, Doctor, I ...

A. (Inaudible - audio).

Q. Go ahead.

A. Sorry. In Guysborough they know me with the first name because my last name have (pronounces phonetically) and it's difficult to pronounce. So I chose to go by my name like Dr. Ali is ... they call me by that, like this, Dr. Ali, yeah.

Q. Okay. Dr. Ali. So I ...

A. Thank you.

Q. ... understand you're currently practicing medicine in

Toronto?

A. That's true.

Q. How is Toronto?

A. Today there was a collision on the highway and I was worried that I cannot make it on time to arrive on ... in front of the screen. So hopefully ... yeah, it was good. It's busy. Busy life.

I miss Nova Scotia, honestly, but this is what it is. We have to deal whatever comes.

Q. Yeah, so the ... we talked earlier about the traffic. So it's kind of interesting that that was your issue today.

A. But that's ongoing a little bit.

Q. So Blue Jays or Maple Leafs?

A. I try to not take a side but I would say Blue Jays.

Q. Okay. Good. Right answer.

So, Doctor, I wonder if we could begin a little bit. If you could tell us about your ... the number of years you've been a physician, sort of where you started and the places you've practiced in a general sense.

EXHIBIT P-000262 - *CURRICULUM VITAE* OF DR. ALI KHAKPOUR

A. Sure. So I was graduated in Iran, Middle East. So I entered the university. That would be '90- ... because I know

the calendar. I finished university like 1991. So I went to mandatory service for the rural area and then I served there as an emergency room and family physician. Then after two years I came back to the ... my service was halfway ... I came back to the city, urban setting, and I continued to work as a family medicine. Later on again I was working on and off in the emergency room.

So I started ... I moved to Canada 2003 until the ... all the examination done back and forth and to finish things where I was born. So I started practice 2014 in Nova Scotia up to 2018. In the first two years I was just solely practicing as a family practice in Nova Scotia and ... because there was an emergency room in the rural area and one of the doctors was retiring so I was sent to do the examination.

To be prepared for the emergency room I went to Halifax to do three hours verbal test, written test, two weeks over the ... another week in St. Martha eventually. And four courses ... like, advanced courses, to be trained for advanced normal life support, advanced cardiac life support for the children, intubation, all these things done. So I got the permit to work as a emergency room physician in Guysborough.

So I was working, like, back to back with Dr. Mahendrarajah

Ranjini and, of course, Dr. Bell and every other day I was on call. Every morning I was a family physician and every day I was a hospitalist responsible for those patient who I had admitted either from the office or from the Emerg directly to the ward.

So my contract ended up in 2018. I continued to serve when they were short after Emerg coverage as much as I could because my wife has kind of heart condition that I should attend to her in Toronto. So eventually, I moved more to Toronto and I started a walk-in clinic practice. To explain more, it's like a family medicine but in the kind of that you are not linked to a certain patient but you serve as like a family physician at times that the original family physician is not available.

Then I moved to the current office that I'm sitting. I'm running this clinic with another doctor. So here the service is again family medicine and walk-in, and we are picking up patients gradually to become stable like a family practice once again.

Q. So, Doctor, I'm going to circle back and sort of break your long career into sections and just ask a little bit about your experiences. So you practiced medicine in Iran?

A. Yes.

Q. And during your time of practicing medicine did you have clients or patients that had a military background?

A. For sure. You ...(inaudible - audio).

Q. Oh, I think you're ...

A. ... was in Iran and then neighbour country, Iraq. Excuse me?

Q. You were just ...

A. Should I continue?

Q. You were just breaking up a little bit. So if I can get you to restart the answer there.

A. So I am like five meters away from the modem. If you think that I cannot have a good connection I can pick it up and go to the other room. Maybe closer. Is it becoming broken, the feed?

Q. It just ...

A. My voice is becoming broken?

A. It just did for a moment there, but we can ... I guess we'll turn it over to Judge Zimmer.

THE COURT: No, it ...

A. Sorry it happen.

THE COURT: So Dr. Ali, you were fine and then there was just a little tremor in the audio for a moment and then it seems

to have corrected itself. So it may be just one of the vagaries of the internet. We'll continue, and if we have another difficulty we'll see if we can make some changes to correct it.

A. Sure, Your Honour.

THE COURT: All right.

A. Sure, Your Honour.

THE COURT: Thank you.

A. Of course.

MR. RUSSELL: So what I was asking. In your practice in Iran your client base that may have had a military background. If you could tell us a little bit about that.

A. Yes, as I ... yeah, just because it was a wartime when it was ... when I entered the university because it took eight years. So we had patients arriving from the battle zone back to the major city hospital. Because it was a teaching hospital. Of course, so we had many of those people who had chemical injuries, physical injuries, emotional stresses were hospitalized back home ... back to the university hospital. So as a student, from the beginning I saw those people on ward. And later on, of course, because so much casualty, what happening between the two countries, many people with PTSD were coming to my practice. That ... so I have been familiar with

this issue long time.

Q. So there's a term, "operational stress injury". Are you familiar with that term?

A. Yes, I am.

Q. So when you say that you ... in your experience dealing with military members who had operational stress injuries as a result of their experiences in war?

A. Yes.

Q. And what type of mental health struggles did they present with?

A. So those who have lost their limbs, they have become, like, disabled. They walked on a mine or something. So they would have really more toward the depression because their life was totally derailed to another direction. So you could see. But most of them would have anxiety and were ... what is that, repeated dreams or ideals about what had happened in battle zone.

So what I can explain that often when they are supposed ... when they are sitting and something drops on the floor. So normally everyone will react because something drop. But those people who have these things they'll react more. They become, like, overwhelmed suddenly. So too much noise, too much voice,

too much crowded around them. Or with seeing of violence or movies can aggravate the problem. You can see them like this.

Q. And so for how many years would you estimate that you had seen a steady flux of patients that would have suffered some form of operational stress injury as a result of their time in the military?

(09:40)

A. To be honest with you, because I finished university in 1991 up to when I came back to the city still I would meet these people because they were, I mean, continuous of this treatment. Maybe up to ten years after the war was finished I could see people coming for the service. So they become chronic or they are treated with the psychiatrist.

So the number of those new one arriving was in the first five years that I was finished ... I finished school. But maybe in ten years after I finished I see many of them. But every now and then people come and you understand that they have been ... even tortured because ...

Am I interrupted?

Q. No, no, I just ...

A. You're okay? No, no, no, your picture was frozen for a second. I was worried about it and turned it.

So yeah, you could see many of them, I mean, after that because of the emotional injuries that they have suffered. Especially because those people have suffered torture in their political kind of prison services. You have those post-traumatic stress disorder about them, too, which thank God we didn't see such a thing in Canadian people. Never.

Q. And I understand, yourself, in terms of your own qualifications you had a previous affiliation with the military of some kind? If you could tell us what that was.

A. I don't know if it's really affiliation. We can call it, but that's mandatory service for every male Iranian people who comes like 18 to go to the military service. So that's an obligation. You cannot enter university until you register under that service. So that's what I did. So you do the registration. Then they let you to write the examination. I went to the training service for three months and maybe four months. Even I was sent to the major cities just behind the battle zone, but fortunately, because I could pass the exam I was withdraw back to the university. So I continued to do the graduation.

So after that the person might go back to the service with a high-ranking because then you are like a doctor or Master of

Science. But anyway, that's an obligation.

I was in a training. So I had to experience how painful and how difficult it's for a youngster to become just detached from the family and then I remember the day that they said to us that, This is the paper you write if you are killed in the battle zone, who is going to get your corpse?

So I would give my brother name and that was on the first day of training. And they say, You know what, forget it, you should have given you after the end of the month free. Giving you one month. I'm not welcome to the heaven. So yeah, I had a experience to be trained and to live in the mud in the nighttime and training those things.

Q. So we've heard from ... you obviously wouldn't have seen, but ... or heard but we've heard from other clinicians, whether they were psychologists or psychiatrists, even nurses, that talked about under ... the importance of when you are ... when you meet with someone from a military background, a patient from a military background, presenting with some sort of psychological trauma, they talked about the importance of understanding the military culture and having experience in dealing with similar-type patients. I wonder if you could tell us a little bit about, from your perspective ... who actually

comes from and appreciates the background and has the experience treating those patients with those backgrounds. Is there any advantage to that and, if so, what is it?

A. I would say because I have seen two different cultural conditions ... status ... so those people who have been military service back in Iran are different from the military service back in Canada, and this is kind of personal experience because I have seen two different cultures and two different settings.

So people over there, when they come to you, they are more retaining the problem inside because they have been instructed to be solid and, Go ahead, this is your job. So like make an example, you would ask here in Canada, What do you want to do, what is your choice, really, do you want to become a soldier or, no, you choose it? But over there it's just obligation. You can't say, I don't want to.

So you learn to adapt yourself. Those people over there are different from the military service people you see here. But make it brief, what it shares both of them when they arrive, when you talk to them, you can pick it up if, How is the situation ongoing? Everyone has trauma. I've never seen somebody working in military to be, like, really trauma-free.

But kind of some of them manage it and some of them cannot

really. Depends on the background of the person. That is the reality. Because all of them are suffering the same thing.

Q. So when someone like Lionel Desmond, and we're going to get into your interactions with Lionel Desmond, but they present to you for the first time or the second time and you become aware that they're presenting with some questions about their mental health and you're aware that they have that military background and perhaps some trauma connected to it. Do you approach things maybe a little differently than, say, the average civilian presented to you with some trauma?

A. Sure, sure, when somebody comes from military or police or first responders you notice people are under so much stress and you interact more to them. So what this is the fact if ... for the first time in Emerg somebody arrives I would go thoroughly to all different (inaudible - audio) to understand.

Am I disconnected? So there was interruption again.

Q. You did disconnect. So we'll sort of roll it back. If you wouldn't mind explaining what the difference is in the approach.

A. So what I'm saying is that, yes, I know that person arriving from a military background ... for sure they are very different from people who are the Syrians, they have not been

under stress so much. So you become more cautious. You become more kind of vigilant to know what is going on and you'll probably investigate more if this is the very first time you interact with the person and ... because you have to make sure person is safe, what is going on.

But about Mr. Desmond, he had been seen by the psychiatrist many times. So my assumption at the time that I met him was that he has been diagnosed, investigated, serviced, and I am just following up to refill some medications for him; that he has been on this before.

Q. So we're going to get into Mr. Desmond in a little bit. I'm more, at this point, interested in kind of asking you a series of questions to see if we can get some insight about how you approached things given your experience with similar-type patients, and I guess you mentioned earlier that as a rule ... I understood that some military veterans may, on average, appear more guarded in their disclosure of symptoms and trauma? Would that apply to veterans in Canada as well?

A. I would say yes. Because kind of it's a shame that you are not compatible to be a real soldier. So by default, person tries to show himself solid and fine. But it is to ask the person to see ... to make a chemistry, to make like a

relationship, physician and a patient, to try to get the trust of the person to ... that this things will be confidential. Is there anything that makes you worried, is there anything that is ongoing on your mind that bothers you?

So I will do this, too, when I see somebody with a military service. That's first to make a trust relationship and they try to open up if there is something going on with them. But about Mr. Desmond ... oh, you said about him, we will go back later. Yeah, I would make a connection like this. As I mentioned to you, we go from there to understand that if there is anything currently ongoing on the mind of the person that is the number one problem; that what if he walks outside and does something to himself or others?

And then you go further on to see if he happy with everything, especially home and the job. If somebody has been, like, out of the service that's another story. But to see if you could do something to change their settlement or sitting that is working. So I enter from that direction and it works. I have been positive of this. It gives a positive result. When you go ahead like this and make a good chemistry they open up information to you.

Q. So have you had sort of examples of direct experiences

where either an active military member or a retired veteran presents to you in some form of mental health crisis or struggle ... that it became apparent to you that they're being a little more guarded and perhaps they're not disclosing everything that ... I think there's a little bit more. And how did you approach that?

(09:50)

A. So that would happen ... that happened back home because people over there are told to be solid more than here. So yes, those people try to keep themself fine to show that they are okay. But in Canadian system, because this culture is not existing here, they will explain to you better. After a few minutes they will disclose what is going on in their mind.

But in the Middle East culture it's a shame that you are not a good soldier. So they try to keep to themself to show up they are fine. So I would say I would rely on more what I pick up from a Canadian soldier rather than somebody from Iran because here people say, You know what, I don't like this, I don't want to do that. So they are trained that, This is your life, you decide what you want.

So to explain what ... to go back brief. Over here in Canadian system I don't think that they do it like that much

back home, that they try to hide or conceal the issue. They will open up when they trust you.

Q. Okay, but it is ... would you say it is something that you still have to be mindful of when treating a Canadian soldier or a Canadian veteran?

A. Sure. It still could ... it seems it could be present. Depends on the personality of the soldier.

Q. So, Doctor, I'm going to ask you a little bit about your time in Guysborough and at the Guysborough family clinic and the Guysborough ER. So what years did you practice there in Guysborough at that particular hospital and clinic?

A. Okay. I started on January 14th, 2014 exactly to January 14, 2018. That was the exact time of the contract with the Nova Scotia Health Authority. So it could be like I started to take over the office and the things maybe in the beginning of February 2018 up to 2000- ... sorry, 2014 to 2018.

But I was there back and forth a few times to cover the emergency room and also the family practice as a locum for Dr. Bell. Maybe two times or three times overall between 2018 and 2020.

Q. So I just want to ask you a little bit about ... and we heard from Dr. Ranjini yesterday. But a little bit about the

operations of that particular clinic. So between 2014 and 2018 how many doctors or physicians would be part of that? Was it a joint practice between multiple physicians?

A. Yeah. So there was the late doctor, Dr. Foley, the lady doctor who served community about 40 years. She was there when I arrive and she was retiring. She was in her 70s. So other doctors would be Dr. Barbara Bell and Dr. Ranjini, Doctor ... if I pronounce it right, Mahendrarajah Ranjini.

So before I took the license to work in the emergency room that was Dr. Foley, Dr. Bell, and Dr. Ranjini to cover the Emerg and then Dr. Foley was decreasing the number of days and then there was Dr. Ranjini and Dr. Bell for the ... for the Emerg. I was doing just what about family medicine. Of course, we would participate in a weekly gathering of us, the radiology people, lab people, physiotherapy people, to discuss about the community people; that they are served by remote nursing travelling to them, what is going on board, what is going on the work, and that was every Friday. And that was very good. I liked the quality of the service we had over there. So after ... in 2016, in the last two years.

So I took over instead of Dr. Bell to work in the Emerg after I take the qualifications and passed the exams by Dr.

Ross, who is the ER physician in Halifax.

Q. So we've heard this concept of family doctor. You know, Person X has a family doctor and this is the name of the family doctor. So given that there were multiple physicians practicing at this clinic, were there also sort of locum doctors, such as Dr. Harnish, that might come in from time to time?

A. Sure, that's true. That's true. So if I ...

Q. So go ahead.

A. Go ahead. So if I want to explain how the nature of work is there is that if a patient is under the roster of a certain doctor what happens, this doctor is the most responsible doctor for everything, for every activity, back-and-forth letters, referrals, and instruction of the specialists. But if this doctor is away for any reason, for any training or vacation or whatever or any urgent possibility, when a patient arrives to the clinic and has some issue that patient is not left alone unattended. One of the other doctors would take over and would have the file on the ... either on the screen or the paper chart - which some of the patients were still on the paper chart - and look to see what should be done, what is left, what is to be handled next.

Q. So did such a thing ...

A. (Inaudible - audio) doctor comes back.

Q. Did such a thing exist where there was ever a definitive family doctor? So if someone went to the clinic ...

A. Yeah.

Q. ... was there an assigned family doctor, or no, there was never such a thing, it was sort of whatever doctor you got on any given day?

A. No, no, no, no. As I mentioned to you there was assigned. So it's still ... some people, they know that I'm their family physician. Over there if they ask you, Who is your family physician, they say Dr. Ali. Because I was their family physician. So people are rostered under the name or register under the name of a certain doctor. That doctor would receive all the papers related about that single patient because that's kind of focus.

But collaborative medicine helps if that person is not working on that day and the patient needs some help. Another person, a doctor, can take over to look inside the chart and continue the service.

Q. So do you recall in your time at Guysborough who was the assigned doctor for Lionel Desmond?

A. I believe that was Dr. Ranjini. Dr. Mahendrarajah Ranjini.

Q. Okay, and what makes you believe that that was the case?

A. If you look at the charts, emergency room charts, when the patients enter in Guysborough Hospital, on the top it says, Who is the family physician, and, Who is the doctor in the Emerg? So you can see who is the kind of assigned doctor or registered doctor.

Q. I'm going to ask you a little bit about the record system as it was in Guysborough. So in terms of ... say, for example, Lionel Desmond sees you on a specific date but on previous dates he might have seen either Dr. Harnish or Dr. Ranjini. When you see Lionel Desmond do you have access to Dr. Ranjini's and Dr. Harnish's previous reports from the Guysborough clinic?

A. Yes, I would have access. Dr. Harnish would use the computer to write the note, whatever he wants. I believe Dr. Ranjini, at the time I was there, she was using the paper base, that kind of choice that you can make that you want to use computer or you don't want to use a computer.

So if somebody is Dr. Ranjini's patient most often paper

chart would be like paper-paper. But if it is ... if it was my patient or Dr. Bell's patient it would be on the computer basis. Yes, you would have access to both of them. The computer is in front of you. Because I would work with computer. So whoever had put the notes in computer, easy to scroll down and you find the previous note.

But if you want to become suspicious about something, that it is something wrong, then you have to ask the ... wish they provide you always outside the room with the chart of the patient. Then you have to bring the chart in and open to see what was the special referral about or something back and forth.

Q. So I ...

A. If needed.

Q. So I guess when you say that a computer is in front of you what was ... do you remember if there was a name of the system that you would use to be able to bring up a patient on the computer screen to see when they're ...

(10:00)

A. So by default, what is happening when the person arrives is secretary would put the patient's name if I am taking care of the person, for me on the computer. So if another doctor who is using the paper is serving that day I didn't ...

because I did not have access to her login to see what is happening she might have it on the screen and the paper at the same time.

But about myself, I can talk, is that whoever comes to be seen the secretary at front desk would put the name on your chart and you scroll down, get the name and date of birth, phone number, whatever, and the database which is available on the system would come up with the person and then you type in and it would be registered and the time would be fixed. It's the same as somehow that you cannot change the time. When you finish something, the note is closed, it's signed out, it's signed out, dated, finished. That is the security of the kind of, to make sure that you do a good practice for the patient. You finish the job, whatever you do. Nothing to be changed. Nothing possible to change later on.

Q. So you indicated, say, Dr. Ranjini would use a paper chart. She wouldn't make her entries into the database. So would there be times where you maybe wouldn't know of the existence of a certain visit that a patient that you're treating had with Dr. Ranjini because it wouldn't show in the system in front of you on the computer?

A. Yes, but what I want to say is that as long as I

remember when I was there a few years ago, that was how my colleague, Dr. Ranjini, was working. And, yes, if it was needed, then I want to know ... suppose who changed his medication? Either I have to ask Dr. Ranjini or ask the paper copy which she has finished her job properly, to look at it, what is inside, to know what is going on. But I don't know if she's using, right now, the system.

Q. That's fine.

A. ... by writing or what. That's another so this is not related to me.

Q. So in terms of patients that might've been treated at another hospital. So a patient presents to you in Guysborough and they were treated at St. Martha's in Antigonish, would you have access, at the time, to the chart, the notes, from St. Martha's in Antigonish in front of you on the screen?

A. So this could not be said yes because the process would be like this. Imagine somebody is seen, even by me, so a specialist in Antigonish or St. Martha or Halifax write the response. It wouldn't be sent over with the electronic system. It will arrive with the regular paper, printed mail, like comes in an envelope. So the front desk would cut them out, bring it over to you, to your attention, that this is the letter coming

because you referred the patient. So you would read what is the content, you make a decision, you sign it that you have seen it, you leave it back to the front desk, they put it on a certain spot, then when they are finished with the day work or what, there comes a time that they go to pick up these documents, then they scan it to the system.

So there's a time process between these things. A letter is arriving by mail, it arrived there to be seen by the original, most responsible doctor, signed, go back, then it's scanned to the chart.

So what I am saying is that it's not no guarantee that you see the patient was seen one ... like, five days ago. It is for sure on your screen. It could be there or it could ... depends on the load of the activity that the clinic has had. And, of course, clinic was really loaded helping, serving about 18, 20,000 in the community.

Q. So I just want to ask you a little bit about that. Had you had an experience where a patient is in front of you, whether it's in the ER in Guysborough or in the family clinic, and then there's mention of, I was treated at another hospital? And, at that moment, you would have liked to have seen that information but you didn't have it.

A. Yes, it is possible. But also ...

Q. But had you had experiences of that happen?

A. Yeah, it could happen, but what you can do if this is a serious matter and something that makes you become concerned about the patient's condition, there are kind of softwares that ... not softwares, I mean applications that are present, like MEDITECH that would connect you with Guysborough to Antigonish. Or some other broader ones called, I believe it was SHARE. That if you have access to that, that should be a sign how everything fixed to even, like, broader spectrum through the Halifax area if there's something you want to take into it to go find more about the patient.

I think, in the jurisdiction of Nova Scotia, there are some softwares that, if really something is needed to be checked, you can go but, again, the condition is that those papers that was generated would have been scanned to their own system in St. Martha if it is not scanned there. So it was not like that, Dr. Slayter would respond to me, like, electronically, and I see, like, an email, it arrives to my chart. Then like this (snaps fingers), it's typed, like, in a second ago and it's like ... it goes in the tradition of paper. They should have a scan it so with that MEDITECH, whatever, then I should be able to see if

needed, yeah.

Q. And did you have access to MEDITECH and SHARE?

A. I had access to MEDITECH. With the SHARE, we set it up two times, but it was kind of, I don't know what was wrong. And that's something that we password change every now and then with these things, and they were about radiographic passwords, about MEDITECH, about SHARE, and about two other things that, each time (inaudible - audio). So I didn't have access to SHARE. I remember it was not working for me, but I had access to MEDITECH.

Q. So I'm just going to back up a little bit. So what was the reason - and we're going to learn a little bit about the SHARE program and the importance of SHARE, and SHARE actually has information that MEDITECH doesn't - but what was the reason why you didn't have access to SHARE as an ER doctor in Guysborough and a part of the practice in Guysborough?

A. As I mentioned, I had access but, for some reasons, each time when you want to go to work with it, there was some glitch or something wrong. That was not somebody was taking it away from me or I didn't request it. It was accessible, but, each time I went for it, it was a problem. And it would be needed very, very rarely. The reason is that SHARE would be

only needed if somebody is ... you send somebody with the ambulance to the emergency or operation room in, something like in Halifax, a trauma or something. If you want to follow up, usually, which you don't need to follow up. If you want to have access to the information, they sent you something, or you want to see what is going on with the patient right now, what is the O2 sat. or what ... which is not really something that you can manage. It is out of your business at that moment. Just because of curiosity, that could be about the SHARE, but if somebody has been seen - imagine that with the facility in Halifax - and you want to have the information, yeah, that's the time that SHARE is helping you. Most of the elderly that we had with the long, chronic illnesses that we had, they were around us in Guysborough and St. Martha. Rarely, they would have gone for major issues like heart surgery or something up there, and still the paper of those things would be available for the SHARE.

What I'm saying is that SHARE is not so much needed because Halifax was removed and we touched with Halifax if needed. And, most of the time, you do this by either phone and make a phone call and things are finished rather than go several security lines because of confidentiality to get notes to internet to

Halifax and Quebec.

But MEDITECH was used almost every day because that was the mother hospital, St. Martha, for us - 60 kilometers away - so we would know to note, somebody I sent for the surgeon today, what is going on? Is the patient coming back? Should I do something in advance when the patient is arriving? There, you could go on to the MEDITECH and open up the reports of the nurses in the post-operation room to see what's going on. That kind of real time information.

Q. So my understanding of SHARE, if, say, you see a patient today in Guysborough who is presenting with, in some form of mental health crisis, but, last week, they appeared in Sydney hospital, Cape Breton Regional Hospital, for a similar complaint, is SHARE the system that would document there was an ER visit last week in Sydney?

A. No.

Q. No?

A. No. No. You should go in the person's chart to know which direction you want to contact and where are you looking for to find the information to know what is going ... It's not like it's popping up that something was going on on this person or alert pops up. It's just a database. Again, it should be

seen and scanned in any hospital does those things. And, still, the system is not a computer to the database directly. Things go with the old-fashioned paper. I don't criticize it, even I can't say any other province is over Nova Scotia in that manner. Everything is like this. Even here, people believe that we have access to a previous record of their previous family doctor and we say, No, it is not like this. You have to ask them to forward a statement or how you are not connected.

(10:10)

Q. So the way the system operated, and we'll learn a bit more from other witnesses how it operates now but, say, in 2016, if that same scenario. You're operating in 2016 in Guysborough. A patient presents to you in a mental health crisis today. They appeared in Sydney hospital last week and they didn't tell you that. They didn't disclose that. On the tools that you have, would you know that they appeared in Sydney last week for a similar complaint?

A. If you look into the SHARE, I believe you can find it.

Q. What if you weren't accessing SHARE? Would you find it?

A. No, because MEDITECH goes with the small area, like, up to Antigonish, I believe. Cape Breton was not covered, as

much as I know. With this, if you want to go that side, you have to have the SHARE.

Q. Let's do a reversal. Same facts, but instead of appearing in Sydney, they appeared in a hospital in Yarmouth. Would you have access? Patient doesn't disclose to you that they presented in the ER in the form of a mental health crisis. Would you know that they appeared in a Yarmouth hospital?

A. If I understand it right, until you open the SHARE and look into this, you wouldn't notice.

Q. Okay.

A. So what I'm saying is that it's not an alert or note arriving to your system because of the presence of the SHARE to tell you, By the way, this person has been over there for some other reasons.

So another, like, similarities, was the medication, controlled medication like narcotics, and those things that are being dispensed under the care of that booklet that you write, papers, copies, remain. So for those ... I had a patient that comes to take medication, so I, in front of that person, I open the computer in Guysborough, I put my password, and I said, You got 180 of these tablets in that pharmacy in Halifax two days ago. And that person was, like, frozen - How would you know

this? So I said, We have access like this. Because it was possible, like, that information is there, but you have to go for it, if needed.

But what I'm saying is that such a system does not exist. Especially, that would be nice, if it is existing for the psychiatric condition, to tell you right away, Your patient was seen yesterday in Yarmouth. Then you would know, oh, something was going on. Then you have to go look for it. Until they don't come to register and you don't go for it, you cannot know about if something happened over there.

Q. And could you say where a system, if it was a system that gave you that information and said, Your patient, by the way, was in Yarmouth last week. He was suicidal. Would such a system be helpful to you?

A. Yes, of course that would be, but if ... I have received about other patients, things like this, but that was a letter from authorities of that hospital that you are registered on the system as a family physician of these certain patient. We have seen her here for this and this, be aware these things have been done and she has been forwarded to that facility.

So by that letter arriving to me - or sometimes they phone call you that there's something urgent - then you pick up the

phone and follow up to the next facility what is going with the patient and connect with them what to do. This is something that people call you when it is something urgent happening like this. But if this information is information set up on the kind of database, nothing pops up in front of you to say right away, There's something wrong happening with that site. You should be following up, you do something.

Q. You indicated that you had your own personal frustrations, I guess, with SHARE. Do you know ... and I know you can't necessarily speak for other doctors, but was it sort of a shared experience amongst physicians that maybe wasn't just unique to you that you were struggling with the SHARE system?

A. I have seen, when they want to log in, there should be some kind of tricks that you ... not (inaudible) tricks. Yes, there was some difficulties sometimes, yes. Because of security and legal matters about the information of the patients, the login is, by itself, an issue. Then you log in, the computer that you are using should be certified by the system. You cannot use it from your laptop from the home or whatever. So there are encryptions of data going back and forth between the database and your computer when you are sitting in Emerg.

So all these things make it a little bit difficult, but

whenever I needed to use it, I would log in with the password that I had. And as I mentioned to you, every, I believe, three months, they would ask you to change it to something else and that was five or six sometime to be changed.

Yes, it was possible to look in, but it is not something ... maybe I didn't work so much with it, but each time you go it is not like one, two, three. But MEDITECH was a little bit more friendly, maybe because not that tight by security matters involved like SHARE.

Q. And I guess ...

A. And I believe SHARE ... yeah. Yes, go ahead, please.

Q. So is it fair to say that when you're seeing, as a treating doctor in the ER, it's a busy atmosphere. Is that fair?

A. Busy by being focussed on the SHARE or busy by (inaudible - audio). I'm broken again.

Q. So ...

A. Did you ask me if there ...

Q. So busy in the sense of treating clients ... patients, I mean.

A. The number of patients arriving in Guysborough might not be as many, but because you are having the responsibility to

be downstairs in the office as a family medicine, people are waiting for you and, at the same time, you are serving the people arriving upstairs. So that makes it like being busy, kind of doing two things at the same time, because if you are Emerg doctor like in Halifax, you are Emerg ... like, you see one patient half an hour, you walk around or you go relax because there are seven doctors in the centers, there are at least four, they work, and then there's no rush. But when you are in a rural area, you are tight of time because ... not because many patients, although it could be possible you have three patients at the same time, but mostly because you have responsibility to be down there in the clinic to serve people that have been assigned for the date to come to see you or for other doctors that are not present. That makes it busy.

Q. So you explained you're at the ER and you're going back and forth to the clinic. Would easier access, from your experience ... I'm sure someone from the Health Authority may say, Look, SHARE is easy to navigate, but your experience was not as easy as you described it. Would there be things that would make it a lot easier in your world if SHARE was a little simpler?

A. Yes, of course. 100 percent of course, because the

time that you have to put to sit behind that ... even I remember the computers upstairs had access to SHARE, not downstairs in the clinic, what I remember. Because this is something that should be loaded to the computer because of security matters, then you log in, what I remember. But what I am saying, yes, if it was easier to work, that would be, like, really an asset to work easy with something, to go to find ... one, two clicks to find what is going on. That is one of the things that stops you.

So, honestly, if somebody comes with a serious matter, yes, you have to go to the SHARE. But if somebody comes with, like, a twisted ankle or something, of course, it doesn't make sense that you put the time that you should run between. And, also, there is morning reports that we have, like a teaching school hospital, which is a ten-bed hospital, but I like the way it was worked. So every day, we would walk through the patients and have morning report. What was going on last night, to hand it to the next person. So properly and in a really, really university base.

So what I'm saying, all these tasks are on the shoulder of the doctor in the morning to read the morning report and the weekly report, to be in the Emerg, and also to the ... what is

that? To the clinic downstairs. So that makes it kind of a little bit busy.

Q. Okay. So we're going to turn to Lionel Desmond directly. I'm going to bring up Exhibit 92 and we'll start at page 14. They'll bring it up on the screen as well, Doctor.

EXHIBIT P-00092 - THIRD DISCLOSURE - OCTOBER 9, 2019 FROM ADAM RODGERS

A. Sure, thank you.

Q. If you're having trouble seeing it, just let us know.

A. Oh no, I have it in my hand. I have this version of ... I mean a copy.

(10:20)

Q. Okay. And so I believe in this chart it says: "December 13, 2016, at 6:19 p.m." I understand that you were working in the ER in Guysborough at that date?

A. Yes, that's true.

Q. And you would've seen Lionel Desmond on this occasion. Do you recall what it was for?

A. Honestly, I don't recall it. What I learned is that I know he came for a finger cut which I closed, controlled the bleeding with the sutures, but until I read my own note, I didn't remember which finger was it.

Q. Okay. So would this be, to your recollection, and I guess with your notes, would this have been the first time you would've met Lionel Desmond?

A. I believe so.

Q. So if you could tell us a little bit about the cut finger. Did he require any sort of medical interventions?

A. No. I could manage it myself, but the point was, when I read here, I can understand my writing. There was on the fourth finger between ... over this joint, so even I could see the joint capsule because of the depth of the cut, so it was about two or three centimeters over here, but because the depth of the cut was, I mean, there was bleeding, actively bleeding, like a small arterial bleeding. So I used a compression. It didn't help. Then I used sutures and controlled the bleeding finally. It was successful and I think that the healing process, when I see the next notes, they were going fine.

Q. So did he give you an explanation, and did you chart an explanation, for how this injury came about?

A. Yes. He said to me that he was washing a dish and the plate broke in his hand, so that kind of porcelain or whatever was sharp and cut his hand. And he was kind of convincing to me because he didn't look weird or agitated or unhappy or

something, that somebody comes to you and says, Yes, I broke a glass in my hand and this is it, and then you go ahead. He said to me that he was washing a dish and it broke in his hand.

Q. And you accepted, without sort of any difficulty, his explanation for how he cut his finger?

A. No, absolutely, that does make sense that he is telling me the truth.

Q. Okay. Did he present to you at all in any sort of distress or show any signs of any sort of psychological struggle that he was having? Anxiety? Depression? Flashbacks?

A. No, not at all, because I am so careful of these things that if somebody comes ... even when you talk to the person, if the person looks, like, tangential, they don't look different. I have been almost 30 years a doctor, so I will pick it up that the person has something other than his finger cut with him, which he didn't have anything. He said ... I mean, he looked completely reasonable that, If I cut my finger like this, and he was looking for help and to fix it and to close the bleeding and to get healed. So this even adds to the condition that if he was depressed or agitated, you can imagine that the person really doesn't care what is going on. There's a laceration. Somebody has been in battle zone, has seen so many

bad things. Such a small thing. It's not a big deal. But he was keen to make it fixed and to go ahead with the improvement. So he didn't look bad anyway.

Q. So if we turn to page 15, I know we didn't ... I don't believe we reviewed this previously. This appears to be a series of notes. I take it that it's not your handwriting.

A. No, this is not.

Q. In the last line, I'm wondering if you could help me out a little bit. It says, "Discharge (something) (something) wife". Do you see that there?

A. Under page 15?

Q. On page 15, so the last written line under 18:55.

A. Okay. "... applied. Patient tolerated well. Applied to assess of bleeding patient." So I'm reading ... are you talking about 18- ... in front of time 18:55?

Q. Yes, the very last line there. There seems to be four words.

A. So very last line. "Reassess". And let me go ... it says roughly tube given ... Keflex 200 (reading to self) given. Lot number like this. Patient instruction. (Reading to self) reassess and that dressing applied to the finger. Adaptic ... that is kind of dressing, digital applied. Patient tolerated

well. Ice applied to assess bleeding. Dispense and wife ..." I cannot read it really what does it say.

Q. So you're not sure what. There's the word "wife". Do you recall if ...

A. I see that, yeah.

Q. Do you recall if his wife, Shanna Desmond, had attended the ER with him that particular evening?

A. On the day first, no, I don't remember, but this is the second day he arrived to do the dressing. That, on that day, the day second ... is this the day second? No, I didn't see her in the ER. Maybe she was sitting outside. But when I left the room, she walked into her husband, probably, because I don't remember her (inaudible - audio).

Q. That's fine, Doctor, and I certainly ...

A. So what I don't ... I cannot read this thing, but (inaudible - audio).

Q. That's fine, Doctor, and I certainly don't want you to speculate. Just when I saw the reference to "wife" at the nurse's note from that date, December 13th, I just wanted to see if you recalled anything.

A. "Dispense (something) to wife." So it could be they handed him some kind of extra bandage that in case ... I can see

this ... something maybe handed or explained to the wife, but I don't know whose handwriting is it. This is one of the nurses who did the dressing on that date.

Q. That's fine, Doctor, I just, when I saw it there, I thought I would check your memory to see what your recollection was.

So the next date, if we turn to page 16, this is the next day - "December 14, 2016, 11:43 a.m. ER physician (that's you and) "Complaint - dressing change." So you met with Lionel Desmond briefly on that date, I understand?

A. No, I didn't see him.

Q. Okay.

A. So the procedure is that, for the dressing, just for dressing only, where the nurse ... that's how the procedure goes ahead. So when you do kind of procedure or whatever you do, when they come to do the change of dressing, the nurse would go ahead because you are pretty busy with other stuff. If needed something that you need an intervention to do additional, then they come to ask you to attend and see the person. Otherwise, they do it by default, by the articles that they have been instructed per hospital.

Q. Okay. So this chart relates to, I guess, the nurse's

contact with him where he arrives the next day for a dressing change. Is that correct?

A. That's true.

Q. So December 19th. So we're going to turn to page 18.

A. Yes.

Q. So we're now six days after you first encountered him for the cut finger.

A. Mm-hmm.

Q. This indicates: "At 10:37 a.m., December 19th, Guysborough emergency care record". And it again indicates "dressing change". In this case, it says: "ER physician, Dr. Ranjini", so would you have been working this particular date?

A. I don't remember if I had been working. What I understand after is his family physician is Dr. Ranjini, but I don't see any note to say that was ... We can make it like this. Let's see my calendar. If it was every other day, that would be Dr. Ranjini or me. So on December 14, if ... I don't have the calendar. I have to go on my phone if it's okay. If I go December 2000- ... What I'm saying, every other day, that would be me and Dr. Ranjini. If this has been on ... and also about the day of the week. If this is December 13, that would be me and December 14 would be Dr. Ranjini. Otherwise, it would

be ... Can I go to the calendar for a minute, please?

Q. So you're looking at the calendar of 2016, I take it?

(10:30)

A. Yes. I'm trying to ... because some of the weekends, there would be two days that you would be in the role the physician in the ... responsible in the Emerg. So if I want to see who was on that day, the doctor on call, I arrive in the December ... in the ... this is December of 2000- ... okay. So when it was December 13 that ... and I was working, that would be a Tuesday then I would be working on 15, not the 14th. So ... but I don't know how I have been working 13 and 14. Oh, it could be I was not working on that same day but the nurse would ask, Who did this suture for you? They would say, Dr. Ali. So, again, for the next day that I was not Emerg doctor, they assigned it under my name because ...

Q. That's fine, Doctor.

A. Yeah, so I don't know who was the Emerg doctor on 19 ... would be a Monday.

Q. That's fine.

A. Okay.

Q. So December 19th. There is a chart note here. What is your understanding of this particular chart note as it

relates to treatment for Lionel Desmond?

A. You're talking about page 18 or 19?

Q. 18.

A. 18. It says the patient came for the dressing change. Old dressing removed. (Reading to self) discharge and finger has ... I cannot read it, really, and sutures (inaudible) around finger somehow macerated. Patient repeats his wife has been ... and dressing change. I see something the patient repeats. His wife ... I cannot read that. H-C-P.

Q. That's ...

A. (Inaudible - audio.)

Q. That's fine, Doctor. So you understood it was just a routine sort of checkup as it relates to his treatment for his finger?

A. Yes, yeah, that was the check for the finger, and it continues to the next page.

Q. So ...

A. Wound cleaned. Yeah, that's explaining about the dressing change.

Q. So my question is ... if we turn to the next page, page 19 ...

A. Yes.

Q. ... there is a nurse's note probably three-quarters of the way down. It said, "Patient had prescription run out and requesting refill." Doctor ... it is Dr. Ranjini on call. Family physician phoned. Do you recall any sort of discussion? It says: "Patient states he will make office appointment for prescription refill." Do you recall this note and whether or not Lionel Desmond was seeking some sort of prescription refill on December 19th?

A. On that day? No. No, no, I don't remember such a thing, but I know that he arrive to see me on December 20 for the ... for a refill. Probably he was looking for a doctor to help but no one told me that he needs ... because that's not a hassle. Before you leave the Emerg, go downstairs the nurses would ask you, Hey, Doctor, this patient needs this prescription and you pick up this from your certain designated area. I had it in my ... that was in the small notepad, like a registered name on it that you write the prescription and you sign it. You hand it to the nurse and the nurse hand it to the patient and the patient would continue to leave the hospital.

So if such a thing existed and I was walking around they would ask me to do it. I have done it tons of time, and it would be written at the right side at this corner. It says ...

the order at this corner of the note. That's where the place is ... that's the place for the notes. If you want to add a Keflex or antibiotic or something that is where you write it and record it that I added this for the patient.

Q. So there's no indica- ...

A. Now no one asked me ... because no one asked me that he needs it. Or if it's supposed to be me no one contacted me. Otherwise there was no hesitation or difficulty for me.

Q. So I'm going to ask you about the next day. So page 20.

A. Yeah, that's the day I saw him in the office.

Q. So you see Lionel Desmond in your office in Guysborough?

A. Right.

Q. And what was the point and purpose of this visit?

A. He had problems sleeping. He couldn't sleep well.

Q. And what did he indicate to you ...

A. And ...

Q. ... about his problem sleeping?

A. And he was ... he said to me that he's short of medication that he has been taking. So simply, I ask him, Is it being prescribed by your psychiatrist? He says, Yes. So I

refill it for him.

Q. And the particular medication that you said you refilled, it's ... what medication is it?

A. It's Zolpidem. It's kind of hypnotic to help the people to fall asleep when they ... when they cannot. It's something that you give the patient that is not able to go to a sleep and helps at least like a few hours, at least for five hours, so patient ... for the initiation problem of the sleep, when the people cannot sleep, this would be used.

And he said to me when he takes it he can sleep. So that was fine with him. So no hesitation. And this is not a big medication to have major interaction with other stuff that the person might be on. So these days we don't use things like ... we call it benzodiazepines like lorazepam, diazepam, clonazepam. Because those things have (inaudible - audio) that might ...

So I waited because I understood I was broken.

Q. Yes, you were. So ...

A. So this medication was safe.

Q. So you were breaking up there.

A. So this medication ...

Q. So we'll go back.

A. So whenever the screen become frozen I understand I'm

broken up.

So what I understand is that ... that's Zolpidem. So Zolpidem is one of the things that cause less tolerance. What I mean is that other stuff that are not used anymore like lorazepam, diazepam, those things make a tolerance. Each time you have to increase the dose, and we don't write it for people. There is a possibility of addiction and tolerance. But these things are fairly ... not fairly, like five years, ten years, and they are kind of safe and the same age after Mr. Desmond. They are not prescribed for very elderly. There had been night-walking, kind of sudden sleepiness the next day. So I don't write it for people, like, above 65 or 70 that can cause problem.

But in young people, middle age, that's one of the best thing that could be given to the person. Especially that he was on this before. So a psychiatrist had confirmed this is the best choice for him.

Q. So, Doctor, that's what I want to ask you about. So this particular choice, this Zolpidem, did Lionel Desmond tell you this particular drug or how did you know that this was a drug that was prescribed previously?

A. No, he said to me that, I need it, and then I scrolled

up. I saw Dr. Harnish note that Dr. Harnish was saying that he was given, like, this by the specialist with the Services. Because Dr. Harnish note was on computer, accessible, easy, just next page, and I see that yes, he was given these things by ... he was on a few other stuff, which he didn't want those thing and like ...

Q. And do you know why?

A. These things. I mean the sleeping pills are not dispensed in the large numbers. Like it's in the ... in the numbers of 30 or something. Because there's a idea in the public that you can use all together to kind of commit something wrong with yourself, to hurt yourself.

So we don't hand the patient like this. Even the psychiatric medication, they are not dispensed more than the load that patient can take all together cause like a suicidal action. So these things would be given, like, 30 of them.

So that is no wonder the person become short of them. When you look at it and say, Yes, he has been given in the time manner he is not using too much of this stuff, so you think that he is not lying, he is not anything wrong. So you dispense another 20 or 30. I don't know how many I give to him. For one month. I just give it to for one month.

Q. So did you say that he made comments about other medication, what he thought about other medication?

A. No. No, he said, I just need something that I have been using for sleeping, Zolpidem, and I checked and I said ... and he was reasonable. So that didn't provoke any sense to me that he's a drug seeker or something that he wants to have. Because this is not really something that people ... drug seekers look. If he had asked for Percocet or something or morphine or Dilaudid something, then you become hypervigilant. Maybe there is something wrong.

But this is something that everyone can have it on the cabinet. This is not something strange.

Q. So I want to ask you about his difficulties, reports of difficulties sleeping. Did he tell you in particular the frequency in which he was having trouble sleeping?

A. He would say to me if he is not taking this he cannot sleep. Like every night he has to take it.

(10:40)

Q. Did he say what was causing him not to be able to sleep?

A. No, he didn't mention. He said, I cannot sleep. Because usually you ask, Is there any noise or something bothers

you? If it ... like a chit-chat that you go ahead like, Okay, what is ... is your partner snoring, what ... or there's any noise in the room or something.

So no, he didn't mention anything specific. He says, I cannot sleep. If I don't take it I can't sleep.

Q. Did he tell you ...

A. That is it.

Q. ... anything about dreams he might have been having or anxiety as a result of those dreams? Did he discuss any of that with you?

A. No, he didn't.

Q. So there's a note that you put down. You said: "He says that still he is depressed with the PTSD after serving Army abroad in war zone." If you could tell us a little bit about that discussion you had.

A. Yes, that's true. I didn't talk about the dreams that you ask me but he said ... because I asked him when I learned that he's a veteran I asked him that, How do you feel, is everything fine? And he says he is not really happy. He is not feeling perfect. He is not good. Still, it's ongoing. That's exactly my writing and my memory helps me to tell that he was saying to me that his mood is like before. Nothing really

changes, like an ongoing issue, that he says to me.

And of course, when he brings up PTSD he will tell me that he was in a battle zone, he has memories of those thing and that bothers him.

Q. Did ...

A. That much he disclosed to me.

Q. Did he appear as he reported? Did he appear to you as depressed?

A. I would say no. When I ask him he said that he is not feeling the best. He is not good. But he was not kind of like a slow-down or ... I don't know, kind of mood appearance - we call it affect - to tell me that this man is not to be left alone right now outside. He was saying that, I'm not feeling well. Kind of conclusion your mind has made with so many times visiting the doctors that ... that I'm not feeling well. Anyway, there is ... they are giving me medication.

So he says he needs some medication. He was not sure of dosings, and then I said, Is there somebody following up with you? He says yes, he is going to see the psychiatrist in a few days and then so that makes me ... that filled me in that he is not depressed to the level that he want to commit suicide. Because he want to see the psychiatrist to get better.

When the patient is looking for the next appointment for the psychiatrist it means that they are keen and they like to get the treatment, get better out of this mood.

Q. And I believe your ...

A. So he was ... he was not ...

Q. Go ahead, sorry.

A. So what I'm saying is that yes, when I ask him, How do you feel right now, he would say, Still I feel depressed. But it was not like that, that you say right now this man ... because fortunately I have experience. I can't say this person is not to be left alone right now. You have to put more time to have him sit here, cancel other patients, ask other doctor to take over to see if you can talk to the patient to see what you can do.

And in extreme ... if something is really wrong and the person discloses to you that they want to hurt themselves here in Ontario it's Form 1 ... over there it's Form 1, too. So you write a letter, that kind of obligatory admission to the hospital, to the ward, so the ... against the person's will. Because you detect that the person might hurt themselves or others then you can keep the person for 24 hours and to see by another doctor to confirm your diagnosis and then the

psychiatrist come into the picture.

Q. So in this ...

A. But he didn't look any way that.

Q. So in this particular case you noted on the second line, you said: "Will see Dr. Slayter tomorrow." So is that consistent with what you said you asked him and he revealed he's seeing Dr. Slayter?

A. Yes, exactly. When I ask him that he ... and he says to me he is going to see his psychiatrist tomorrow, two possibilities come to my mind. First is that he is happy to see the doctor. He wants to go ahead. And again, it's not like next month to say, Okay, there's a time gap that you're going to leave the patient unattended to the community, you're going to see the doctor tomorrow. And he's willing to go. Because he could tell me that, I have an appointment but I don't want to go. Or say, I'm going to see ... to say ... I have patient to say, I don't want to go to see this doctor anymore.

So this means that the person is not happy. They don't like the ... whatever. Not especially Dr. Slayter. I've never seen somebody unhappy with Dr. Slayter. Really, honestly, I respect him. Not about this case, he has been very thorough. Whenever I send a patient I got a big, big letter coming back

with everything comprehensive, to the point, and very good.

So when he says he going to see the doctor tomorrow and he is ... he get to see Dr. Slayter it means that he's ... he has intention to be happy and healthy and he doesn't want to hurt himself, and especially that would be the next day after seeing me. Then I feel comfortable that I'm not leaving the patient for a long time unattended. Although this is not my own patient but as a contact, you see somebody in the office that brings all the ... that brings all the responsibility.

Q. So I'll just get you to repeat that last little bit about "brings all the responsibility". What was that you had mentioned?

A. So what I said is that all of the patient is not rostered under ... or was not rostered under my name was not my own patient. When they come to help for ... to see you, you become automatically the full medicine doctor in front of the person to take everything in care and to make sure the person is safe. So you become at the level of the ... of your ... the family doctor is worried about the patient, you should become, (inaudible) to take care completely for the patient to make sure things are fine with him.

So I found that he going to see Dr. Slayter tomorrow, and

he was really looking ... I can't say normal, that he was not cheerful to make a joke or fun, but he was not crying or weeping or have a mood to have head down or eye ... no, he was absolutely looking normal.

Q. Okay.

A. That ... that's what that mean.

Q. So you indicated in your report, the third line down, you said: "He is not suicidal or homicidal." So did you ...

A. Yeah.

Q. ... probe those areas to see if there were suicidal ideations or homicidal ideations? Did you check for that?

A. Yes, for sure I would do it. This is some of the most important things that I would do in my practice. Even if somebody arrives ... like a teenager. We have people with the image problem. They have an acne on their face and they are happy and they have been humiliated by the schoolmates and classmates. So even they come for acne treatment. I confirm with them, How is your mood, how is everything? To make sure that person does not want to hurt himself. Because for them it could be serious.

So by default, every person coming with a background of emotional state, even not full depression, I don't hesitate to

contact and ask. Because previously it was said that if you ask the person, Do you have thoughts to hurt yourself, it would be kind of transferred to the mind of the person to commit suicide. Later on they say no, this is not the case ... I mean the Canadian literature.

Go ahead and directly bring it up. Is there something on your mind that you might hurt yourself or you'll harm yourself or what? And ask it directly to make sure. And the response does not provoke an action, which I did. Because this is the safety for sure should be done, and I will continue. If I see a patient in about five minutes I will do the same. No hesitation. This is a good question.

Q. So did you recall going through that assessment with Lionel Desmond, coming out and directly asking him if he was suicidal or homicidal?

A. Sure, yes, I did.

Q. And did you get any sort of indication that there were risk factors or vulnerabilities for suicide or homicide?

A. No, because one thing is that the risk factor for this thing is like old, alone, man, had a history be police or military, access to fire guns, history of suicidal attempts, thoughts of this, depression, major illness. All these factors

are risk factors to ... the number would tell you if the person is suicidal.

So he was not old. He was not ... he was a military officer. I didn't know if he has access to the gun, because when you are release from the Service the gun would not go with him. So my assumption, he doesn't have a gun. Then it would be that, Is he living alone? No. Doesn't have a kind of major diabetes, heart disease, whatever.

(10:50)

So he didn't have those risk factors, plus he was eager to see Dr. Slayer the next day. That ... and also back to the history. I see I writing about the finger. When somebody comes four times to the emergency room to get a dressing of a small laceration it means that this person wants to be healthy, does not intend to hurt himself or others ... I can't say others. What I say is that he was taking care of himself positively, looking positive to future to become healthy when he comes four times for a dressing of a finger.

So those things, that was in the background. Plus he going to see Dr. Slayter the next day. He didn't want me ... a major medication that would intend to show that he is in a very low mood or he show at me some word or gesture to say no, this man

is not happy. Because we have experienced people that come and they sit and they look at you somehow that you understand immediately there is a possibility of violence or anger management. But he didn't have any of these things.

Q. So ... and I appreciate that you checked for various signs or symptoms that would put him, maybe, at risk and you took comfort in knowing properly that he was going to see a psychiatrist the next day. When you treated him on December 20th did you know that he had previously been at the OSI clinic in New Brunswick? Did you know that?

A. I look at Dr. Harnish note and I understood he had been seen by other facilities and services. I would know that much.

Q. And did you know the particular ...

A. Yeah, because of the note.

Q. But you didn't know ... is it fair to say you didn't know the particulars of what that involved?

A. No, I didn't know what was the particular reason he was hospitalized. See, my understanding was he was under tremendous stress and pressure and PTSD, which was written by doctor and documented by Dr. Harnish. So that is enough for me to understand and say, Yes, the person arrives in a mental

facility because he is a veteran and he has PTSD.

So that per se, to me, does not say everyone going to that facility would commit suicide the next day, because they ... people go there and many of them ... I mean almost all of them get better to become a little bit normalized to continue life. But some of them would end up in the very sad ... and like Mr. Desmond.

What I want to make is that yes, you see in the chart that this person has been in Quebec. He has been in New Brunswick. But it's not like if anyone is there that means that the person is going to commit suicide the next day.

Q. So ... and I appreciate, Doctor, and certainly, it would be ... it's ... I think it's a fair comment to say it would be impossible for you in this moment to predict what eventually happened and there were a number of medical intervening appointments that occurred. However, I just want to ask you, you indicated that in part of your assessment for suicide risk and homicide risk you would ask about firearms normally, whether they had access to firearms?

A. Yes. Yes.

Q. Do you recall if you asked Lionel Desmond whether or not he had access to firearms?

A. I don't remember I have asked that.

Q. Okay. You indicated as well, you talked about a risk factor of whether or not he was living alone or lonely. Do you recall if you asked him about what his relationship status had been with Shanna Desmond?

A. Briefly when you'd ask: Is everything fine at home ... this is just the sentence that you use about the relationship. And he wouldn't mention anything about. These are the default question I would ask. Like in the school you would ask a teenager, Everything fine at school setting? Because this is the major interaction of the person with the outside world. For the adult you would ask, Everything fine at home? Because he was not working there's no job to say, How your job, how your work at the work environment?

But when you ask, Everything fine at home, he would say, Yes. He didn't bring it up that he has problems, and I read the charts to see he had kind of suspicious idea or paranoid. I don't know. I'm not a psychiatrist to give a diagnosis on this, but what he ... if he had question about his family on that day when I said, Everything fine at home? He would say, Yes, I just want the prescription for the sleeping pills and go away.

Q. Would you have normally asked Lionel Desmond whether

or not he had any past suicide attempts?

A. Yes. Yes.

Q. So that's something you probably would have asked him on this date?

A. Yeah, but he would say he had thoughts. But he didn't tell me that he had committed. I don't know if, really, he had committed. So he would say yes, thoughts are ... but thoughts are not something that you become ... to want to keep the person in a facility. So thoughts may come and go. Then after thoughts are planned, after plans are planned and actively like that, somebody wants to hang himself who would say, Even I went to buy the rope and I tied it and brought down this. So whatever extension the person has gone to the thought, plan, suggests similar preparation of those things, this means this ... this tells the doctor how extensive this idea is (inaudible - audio).

Q. Sorry, I'll ...

A. Just simply merely somebody says that, I had had thoughts to hurt myself.

So what I was saying is that when you ask the person, Have you ever had thoughts? Yes, I had it but I'm fine now. It doesn't mean that you have to keep the person in a facility.

Because yes, everyone, like depressed people, might have at the point thoughts, but he didn't bring it up to me, Yes, I had a plan to buy a rope or did I ... did I ... I did it in my hand the knife, something to say it was actual active action but he didn't commit to suicide.

No, nothing like this. Yes, he would say, I had thought, but I'm fine now.

Q. What if in a scenario where Lionel Desmond had disclosed to you that he did, in fact, have a past suicide attempt? How does that factor into your ...

A. Excuse me, again?

Q. How would that factor into your analysis?

A. If he had tell me that he had some attempt before?

Q. Yes, in the past.

A. So that makes the ... that would have make me more kind of vigilant to him that he has gone to the point to do an attempt but for some reason it was not going through. It didn't happen. So you become ... double-check that, what is going on. Is he being followed up with another doctor? Is he under the care?

Again, if he says to me, Yes, I had done this, and he's not being ... going to see another doctor. Or he says, I hate you

all, I believe the medical system is not helping me, I mean the doctors ... I'm not going to my appointment anymore, what, what. Yes, this means altogether the person is in danger, but even with the actively before, yes, it increase the chance of suicidal but it doesn't predict it, like, to happen 100 percent.

Q. And I appreciate your encounter with Lionel Desmond was fairly brief that day. It's certainly proper that you knew he was going to see Dr. Slayer, the psychiatrist, the very next day. You were in tune with the fact that he was a military veteran. We know from the nurses' notes at St. Martha's that Lionel Desmond disclosed to the intake nurse that he did have a past suicide attempt with a firearm. If I can get that right, just one moment.

So we know that he had, at a minimum, disclosed to a previous intake nurse about a suicidal thought, and it involved a firearm. Would that have changed your sort of assessment on this particular day?

A. On that particular day, no, because he was going to see the specialist the next day. So, again, when you arrive three to four times for your finger and you will tell me that you have an appointment, you're going to see your doctor, all these thing mean, yes, previously. If, even, he had an attempt

to do suicide it increases the chance of suicidality. We can't deny it. But at the same time, on that particular day he was not actively having the thoughts to be concern.

Q. I'm just looking back, Doctor. In fact, I was correct when I first believed that he did disclose a past suicide attempt four to five years ago. "Shotgun", is what he indicated to the intake nurse in the Quebec records. Would that have changed your perspective and analysis from this particular date?

(11:00)

A. So let me explain it like this. If somebody arrives and if he has disclosed to me ... open it to me that, Yes, I had a plan, like, to use a shotgun five years ago back in Quebec. When it is removed in time it shows the chronicity that it has been not a new idea. It has been on and off with the person. It has been removed. But right now under the care of the several facilities and doctors that have seen him, he is not having a thought to do it right now, because I asked him, Do you have any ideas to do any harm or hurting yourself?

Yes, that's true. When you, if you ... if I had known that he had had such a thing, I would note this person has a higher risk than somebody that has not attempt once, but when the person is looking fine, he is on, what is that medication, and

he has been seen and managed in two facilities and specialists, and he says he's fine. He is looking for his health. He is positive, there is no reason, because of an attempt five years ago, to say, You know what? Each time you arrive for even a Tylenol, because you have a thought of committing suicide ... of actively, you had the shotgun in your hand, it is different. Even if you had it, it means that you're going to do it right now, because, currently, you say you are fine. And you see the person is stable.

So I don't just rely on the word of the person to say, Do you have any idea to hurt yourself, and he says, No. And I say, Okay, I'm convinced. Go. What I am bringing up is that when I see the person, he's coming back and forth to get better even for the finger. And, also, I see the note that Dr. Harnish uptake is not, the person is not actively suicidal right now. And I talked to him and my own experience, he doesn't have a sense of having these thoughts, although he had these things. Yes, knowing this gives me an idea this person has no chance, comparing to the veteran who is depressed but had not had a plan before. But this does not essentially mean this person needed to be hospitalized right now because if you go and I say, I have, like, a shoulder pain, they say because you have had a

thought of suicidal idea five years ago, then I have to admit you to the psychiatric ward. This is nonsense.

But if he had disclosed a bit of information to say, You know what? I'm not going tomorrow to see Dr. Slayter, or, I don't like anything, or, Whatever happens to my finger, chop it off, I don't care about it, it means the person is frustrated. It means that you should be, even with no history of attempt to suicidal things, it means this person is in danger, with or without having a visit.

So this is an overall assessment that makes medicine difficult for us because it's not like a number and to say, What do you do next? This is overall understanding of what is going on. And, honestly, if he had shown any single point of showing depressed that much that he might have committed anything wrong, no hesitation that we would do something different from what I noted here. When I wrote that "no suicidal/homicidal", it means that's the abstract, the finish of the discussion with the patient, because, really, typing all this together ... honestly, I'm not in typing, you see it in error. I would assume it was pen and paper. So I have adapted myself to typing completely. Right now, I can type. But it is not like that that you type whatever you talk to the patient immediately to make like this

long. You just try to finish it, one, two and to go there.

But, anyway, I think he was not actively ... or even he didn't have any thoughts and he looked to be somebody seeking help positive.

Q. Okay. Thank you, Doctor. I don't have any further questions, Your Honour.

THE COURT: Thank you, Mr. Russell. Ms. Ward or Ms. Grant?

MS. WARD: No questions, Your Honour.

THE COURT: Thank you. Mr. Anderson?

MR. ANDERSON: No questions, Your Honour.

THE COURT: Thank you. Mr. Macdonald?

MR. MACDONALD: No questions, Your Honour.

THE COURT: Thank you. Ms. Miller?

CROSS-EXAMINATION BY MS. MILLER

(11:05)

MS. MILLER: Good morning, Doctor. My name is Tara Miller and I am the lawyer representing the personal representative of the late Brenda Desmond, so Cpl. Desmond's mother, and also his daughter, Aaliyah Desmond.

A. Good morning.

DR. ALI KHAKPOUR, Cross-Examination by Ms. Miller

Q. Good morning. Thank you for your time this morning. I have just a few questions about the records that are in the Guysborough Medical Clinic file. If I understand it, these records would be the records that were in the family clinic where you worked along with Dr. Foley and Dr. Bell and Dr. Ranjini. Correct?

A. Right.

Q. Okay. And these records include your chart notes, they include emergency room records, and other consult reports. Correct?

A. True. Yes, correct.

Q. So I'm trying to just be very clear, Doctor, with what you would've had in front of you when you saw Cpl. Desmond to refill the prescription on December 20th.

A. You've become broken. Yes?

Q. Did you catch my question? I think the connection froze. I want to be clear ...

A. No, you, my understand- ... about the 20th of December.

Q. Yes, thank you. Now I appreciate that Cpl. Desmond was in to see you for a refill for his prescription or a prescription. In your evidence, you said you would've looked at

Dr. Harnish's note to see what that prescription had been prior to December 20th?

A. Yes.

Q. Okay. And Dr. Harnish's note is at page 7 and 8 of Exhibit 92.

A. Let me bring it up. Yeah, that's what I have it there.

Q. Okay.

A. I think I have it here somewhere as well.

Q. I think it's been brought up on the screen as well, Doctor.

A. Yes, yeah, I have a paper version in my hand. That's easier to read it here. I have it, yes, go ahead, please.

Q. So I'm looking at page 7 and page 8. Is this the chart note that you would've looked at that Dr. Harnish would've made with reference to the prior medication?

A. Yes.

Q. Okay. And it's a typed version, so I assume - and you can correct me - this would've been in your electronic chart, or would've been in Cpl. Desmond's electronic chart, at the Guysborough Family Clinic?

A. Yes, true.

Q. Okay. So you went and looked at that. We see under the bottom of page 7, it says, "Impression - Likely does have PTSD given story plan. Need old chart from Ste. Anne's Hospital. Will request."

A. Mm-hmm.

Q. Did you have an opportunity to read that at the time that you saw Cpl. Desmond and ask him about efforts that had been made to secure his old chart from Ste. Anne's?

A. No, because Dr. Harnish has asked it and he didn't ask me to follow up to see if this is arrived here or no.

Q. Okay.

A. But I see that it was a request on page 8 - that is probably Dr. Harnish's handwriting - to ask for such a chart to be sent over from Quebec.

Q. Okay. And we're going to talk to Dr. Harnish, so we'll ask him about that.

I also understand from this exhibit that there would've been a St. Martha's emergency room note from October 24th, 2016. That's found at page 6.

A. Page 6. Okay.

Q. So my first question is, would this have been in Cpl. Desmond's chart when you saw him on December 20th?

A. I don't know because, as I mentioned to Mr. Russell, that's a time manner that needs these things to be put inside an envelope, sent over to come, to arrive, in Guysborough, and then opened, seen by the most responsible doctor, and then it's scanned back to the chart after this procedure has been done. So, at the time that I saw him, I don't know if this was available or no.

Q. Okay. So you saw him on December 20th. This emergency room note is October 24th, two months before. Would it be reasonable to assume ...

A. Should be there.

Q. It should've been there within that two-month window. Okay.

(11:10)

A. Should have been there, yeah.

Q. Yeah. And you said it would be seen by the most responsible doctor. So we see family physician is noted as Dr. Anita Foley. Was Dr. Foley still practicing in any capacity in October of 2016?

A. I believe sometimes she would appear in the Emerg, but I don't have a really clear answer to you if she was working on those days, but you should ask Guysborough Hospital and the

office, Who inherited the patients of Dr. Foley.

Q. Okay. The next record that I want to take you to is found at page 11 of this same exhibit, Doctor, and it is ... I'll let you get there.

A. Dr. Slayter's note?

Q. Yes, this is his ... you said earlier he was a very good psychiatrist. He did very thorough reports, detailed reports, and we understand this is ...

A. Yeah, that is one of his reports, yeah.

Q. Yes, okay. And it's dated December 2nd, 2016. Immediately above the December 2nd, 2016, there looks to be a date stamp in the upper right-hand corner that says "December 14th, 2016". Do you know if that would've been ...

A. Mm-hmm.

Q. Do you see that? Would that have been the date stamp applied at the Guysborough Clinic when the record came in the mail or are you able to comment ...

A. Yeah, that comes in the mail.

Q. This would've come in the mail. Yes.

A. So what I can say that it shows that it has been entered the system December 14th because the note has been generated December 6th ... or December 2nd, and upper right

corner shows "December 14", so it means that it was ... yeah, I remember I saw this note.

Q. Okay. So you would've al- ...

A. Because this is an official note with the good handwriting. I mean this is the printed version that you can see and that's the psychiatrist's note that you should read, which I did it.

Q. So my question, Doctor, is would this record, this psychiatric consult, have been in Cpl. Desmond's file when you saw him on December 20th?

A. Yes, it was there.

Q. Okay.

A. I mentioned ... I checked it. I saw this one.

Q. Did you have an opportunity to read this note before or during your visit with Cpl. Desmond on December 20th?

A. So I did it after he left because the point is, you want to make sure things are fine. After you finish the cases, you look inside, what is going on, and I saw that, other than the immediate note from Dr. Harnish, I read about this and to see if there's anything to be done next, because sometimes, not sometimes, always, when the specialist gives us a note and it remains in the chart, there's guidelines, advices, or things to

be done next for the patient. Do we see some medications should be changed or the patient should come back or whatever. So, yeah, I read that note when he left.

Q. Okay. And if we can go to page 13 which is the final page of Dr. Slayter's detailed report.

A. Yeah.

Q. Under "Treatment Plan", you would have read that after Cpl. Desmond left. Did it occur to you, Doctor, that there may be a role for a family doctor in your clinic to action the implementation of any of these treatment recommendations?

A. So about the return to the OSI service in New Brunswick, you mean?

Q. Well, if you can take a chance to read through it, there are a variety of different things that are identified by Dr. Slayter, including benefitting from a neuropsych assessment, advising Cpl. Desmond to get his military records, encouraging him to participate in a gym, et cetera.

A. Yeah. Even it was advice to go to the gym and do exercises, those things, I read all these things. Yes, if it comes, so the letter comes back. I saw Lionel Desmond on page 11.

Q. Yes.

A. "In St. Martha today. Referral from Dr. Mahendrarajah." Yeah, this report, this is the guideline and advises that, as I mentioned to you, comes next, that this person has been seen and advice is to do the exercises, those things. And the most important thing is that he believes - Dr. Slayter believes - that he should be linked back to Halifax.

Q. Okay.

A. The services available in Guysborough County is not enough for him, or even Port Hawkesbury. This is not enough a specialized service for him and he should be sent back or linked back to the OSI in Halifax, as he has even underlined this contact "OSI Halifax" writing he needs to be followed up them, or similar services, yeah.

Q. Okay. The last paragraph - and I will read it, Doctor, I'll ask the question - having read that paragraph, did it occur to you at that time that there might be an important role that the family doctors could play in helping Dr. Slayter, given what he makes in this final paragraph? He says:

> I would normally see someone with PTSD only once to confirm the diagnosis and make recommendations. However, given the complexity of his case and given that he

seems to be falling through the cracks in terms of follow-up by military and veterans' programs, I said I would follow him for a short while to help him get connected. I shall focus on treatment and subsequent sessions.

Et cetera, et cetera.

So my question, Dr. Ali, having read that paragraph, did you feel that there could've been a role for the family physician to assist in making sure that Cpl. Desmond didn't "fall through the cracks", as identified by Dr. Slayter?

A. For sure. That's true.

Q. And who was going to be responsible for following up, from a family doctor perspective, from your opinion?

A. So ... because this kind of condition that I don't want to talk about. I can talk about my own practice. So I can make an example like this. So I would say if I refer somebody out or I see a letter comes back to me, it is asking me or talking to me, What is going on? So I am responsible to do all the things that are provided to me to be followed up, which I would do. But that much I know. But about the complexity of service in kind of emergency room and back and forth things in

Guysborough, I don't want to give a hint about this. But what I can say is that if I send a patient to see, imagine, a surgeon, and the surgeon tells me, Do the CT scan and do that one and that one, that is the recommendation. That's why you send a patient out. A referral, I mean. That is to be followed up by the most responsible doctor. Would I say that rather than, Oh, really, if this is a family practice, if Dr. Foley is not there, so who had been assigned next? That person should done it, which my assumption is that this has been handled and followed up.

Q. By the referring doctor.

A. The other thing is that ...

Q. You're ... sorry.

A. Yeah.

Q. Yeah. So your assumption is that follow-up and implementation on a family physician level would fall to the responsibility of the referring family doctor to Dr. Slayter.

A. The only exception I would say is that if that referring doctor would come to me and to say, You know what, for some reasons, I'm busy, or what, or I cannot follow up, or I don't feel comfortable with this patient, if that happened that sometimes that males, kind of violent people, arrive, and I will

take the patient as a family doctor because a man ... because I referred lady doctor that was me as a male doctor.

So what I'm saying, if somebody comes to tell me that, Take care of this note, follow up these things, of course, no hesitation, I'll do it. When ... it's like this. How it works is like this. So any system, any center across the province, even in Ontario, when somebody is back and forth writing, a specialist is giving advice to me. Like, here is a collaborative medicine. Again, I'm sitting right now at this clinic, so we can see each other's patients, but when I write a referral for the, imagine, a plastic surgeon, the advice comes to do MRI, what, what. He's talking to me. So if I don't have time, I'll walk to my colleague to say, By the way, I don't have time for it. Do it for me. Then that would be him following up.

So what I am saying, yes, I read these things and I see Dr. Slayter is telling us the right answer. This is what it should be handled. This person needed special attention. So maybe Dr. Ranjini has sent the patient to OSI in Halifax and ... but as far as I know, I don't remember that she had asked me to follow up.

Q. Okay. Thank you, Doctor, I appreciate your time.

A. Thank you very much. Thank you very much.

THE COURT: Thank you, Ms. Miller. Mr. Rory Rogers. Mr. Rogers, I apologize. I'm a little out of order here, in part because I'm sort of not used to seeing your face in the gallery, but I'll try and be a little better next time through the lineup. Thank you.

MR. ROGERS: No problem, Your Honour.

CROSS-EXAMINATION BY MR. ROGERS

(11:20)

MR. ROGERS: Good morning, Doctor. My name is Rory Rogers and I'm counsel for the Nova Scotia Health Authority.

A. Good morning.

Q. Good morning. I just wanted to touch on a few of the areas that you explored with Mr. Russell, and let me start with some of the electronic access to records that you referenced. Do I understand correctly that you, when you were working in the emergency department at the Guysborough Hospital, had access to the MEDITECH system?

A. Yes.

Q. And that would then give you pertinent information about a patient, including records and documents that had been

generated at St. Martha's? Is that correct?

A. Right.

Q. Okay. And then on the SHARE system, which I think stands - and the Inquiry will hear more evidence about those health record systems - but stands for the "Secure Health Access Record", is it your understanding that that is a province-wide system that provides information about admissions and discharges and transfers from the provincial hospital system?

A. Yes.

Q. And can include information of diagnostic test results and lab test results as well?

A. After they have been scanned to the database, yes.

Q. And that although I understand your evidence that there were glitches that you had, personally, in accessing that system, from time to time, you were able, when you were working in the emergency department at Guysborough Hospital, to access the SHARE system, is that fair?

A. Yeah. Maybe it is because it's a complicated ... to me, I can't say "complicated", but the point is, because of security measures and, but, kind of, it is about technical issues. So, sometimes, you can search the patient with their health card number. Sometimes, you put that when you don't get

a good result. You have to go database. It is kind of these problems to bring up the good data, but still you go there. Suppose you want to see what is the patient being done on his operation. It depends on the connection.

I mean, yes, it is not easy to work. I wish that it was a little bit easier, although I appreciate the person, such a facility for doctors, but I should say that it is not easy to work with.

Q. Okay. And let me turn your attention back to the clinic. So the questions I asked you earlier were in terms of your access to electronic health records when you were working in the emergency department. When you were working downstairs in the family physician clinic, do I understand from your evidence that there was, during the time you were there, both a paper chart and an electronic record or an electronic chart for certain patients?

A. So that's exactly what I say. At the time, downstairs, the computer, which are handled and managed by the health authorities, the software should be installed on them. It's not like an application that you log on the website and you put your password, go in. It should be there. It was not there for a time, so when you were downstairs in the office, you

wouldn't have full access to the database that you have accessed upstairs in the emergency room.

So, later on, I think they tried to fix it a few times. Back and forth, the computers were crashing and people would arrive to reinstall the program, to the point that you prefer not to touch them down there. You come upstairs to work if you need to find the information on SHARE.

Q. Sure.

A. Upstairs in the Emerg.

Q. And I'm trying not to focus your attention on access to SHARE and MEDITECH within the emergency department. I'm focussing now on what the clinic had. The Inquiry heard yesterday from Dr. Ranjini that there was a software program, an electronic health record system, through a company called Accuro, that kept certain electronic records of the family physician patients. Is that your recollection as well that that was the system that the family physicians employed to keep electronic records?

A. No. At the time I was working, the EMR, electronic medical record system, was Nightingale. The Nightingale was, I don't know, purchased or whatever with the Telus communication system and it was supposed to be replaced with another better

EMR. So what Dr. Ranjini has talked about, Accuro would have been probably after I left Guysborough.

At the time that we were there, the software that we work in the clinic, and you see the prints from me and Dr. Harnish, it is Nightingale. So Nightingale, by itself, does not have access, you know those things, to St. Martha or thing. You have to exit that one, go to the MEDITECH and ... or Praxis about this x-ray, those things.

Q. Sure.

A. So that about Accuro, I'm not aware of.

Q. Fair enough. So your electronic note, as well as Dr. Harnish's, were done on the clinic's Nightingale system and that's what you and Dr. Bell and Dr. Harnish used to enter your records of patient visits. Correct?

A. True. Yes, correct.

Q. And then I think you've said, and we heard from Dr. Ranjini as well that her system was not to use the electronic record, which you've indicated is Nightingale, but to use a paper-based approach. Correct?

A. When I was there, she was mostly ... because I (inaudible - audio) of course, I would look at it, but ...

Q. Sorry.

A. ... at the same time, most of the time ...

Q. Could I interrupt you? You cut out at the beginning, so I'll just get you to start your answer now rather than go through all ... wait till the end.

A. So, as much as I know, that time, that she was using mostly the paper format. She was using the paper format at that time. If she had used any extra software, I wouldn't be aware of because I wouldn't look at her computer. What I know is that, mostly, she was using, like, pen and paper, but she might have used the electronic system as well, which I was not aware of.

Q. Fair enough. So when a patient such as Cpl. Desmond came in to see you, or would come in to see you, I'm assuming that somebody at the front would bring the paper chart and you would also have available whatever is on the system electronically. Fair?

A. Yes, that's true.

Q. And do I understand you to have said that you had 20,000 patients at the clinic?

A. So what we have is that, because we cover the whole area from Monastery, go to the halfway to Canso, that way to Port Hawkesbury and this way, if I remember the names correctly,

to Goshen. Somewhere close by the road that goes to the ... I forget the names. So that's a wide area that would be all people around that area would come to your hospital. That is the hospital and the clinic that you cover. I heard that such a number. I don't know how much is this. Maybe 10,000. And that's a good question. I don't know, really, how many of them, but I heard it is about coverage of that big area.

Q. Was your clinic a very busy one?

A. Yeah. Every day, you will be at least 20 patients, at least. So that would be me, Dr. Barbara Bell, and Dr. Mahendrarajah Ranjini. So all of us would have, overall, like, at least 75 patients per day all the weekdays. So, and also, some people would have arrived extra that, for some reason, like, walk-in clinic, that you ... they would be seen too. So that makes it like this number of load that we would handle. And we had, on the top of this, a nurse practitioner that I think she had left the area right now. Maybe other people have arrived after her. So that would be four of us seeing patients every day. That means that, basically, clinic in a rural area.

Q. So with that kind of client/patient demand, would you have time to review the entire paper chart of every patient, or the entire electronic record of every patient, or would you need

to exercise your clinical judgement as to what prior materials might be helpful for you to review in order to assess the particular needs of a patient?

A. That's a good question. Honestly, that makes you tight. Always, always, lagging behind my paperwork. I should come to stay longer time, like the other doctors would the same, to the, like, 7:00. The clinic would close by 5. You have to complete this and read the charts to finish it. Yeah, that's true, but if it is your own patient that - I mean, somebody registered under your name - that is you to go to the full detail of everything. So that is enough for you. But if another doctor's patients arrive to you, really, if it's at the end of the list that you can arrive that one. But, about Mr. Desmond, it was important, so I read his chart. I mean, not the chart, the report of Dr. Slayter.

(11:30)

Q. Okay. And the last question for you, Doctor, relates to some comments that I think you made in responses and questions, that Mr. Russell put to you. And the question I have for you relates to your comments as to the need, on occasion, to ask other sources for relevant information.

So what I'd like you to do is indicate that if you learn as

a result of information provided to you by a patient or from the review of the chart materials that you just referenced, that there might be records available elsewhere, what was your practice?

A. So that is an issue that how you want to gather all these things under one umbrella. So if ... imagine that you have an access of full database of every corner of the province. Like that about the drugs that I bring up in the example that the patient was seeking a medication, I could pick it up. Because every pharmacy that would enter the information I have immediate access. That would be nice, but it could be some patients that see in some hospitals, they don't upload the information to the database. So you might be not ever ... or later on they do it in a different time manner.

So, yes, so it's no guarantee that you have access to all information in one shot, although the system is trying to go that way. And about this information as I mentioned, again back, if this is something crucial that you see the patient is unstable or something ongoing you open the chart immediately to do whatever you do based on Emerg or on the office. But if the patient is stable, just to make sure things are fine, at the end of the day when you list the patient sign out, sign out, you go

back to the chart to make sure nothing is missed to make sure that things are fine, nothing is to be done.

Then I see this note and I said, Okay, this has been provided. Have I been asked to do something extra? No. So I go ahead to continue the service.

Q. And, again, just to come back to the question. If, as a result of an interaction with a patient, let's say somebody who has a summer property in Guysborough County they indicate to you that they have a family physician elsewhere in the province and you think that there might be some material there that would be helpful for what you're being asked to do. Is there a process you would follow in terms of how to secure or request those records?

A. Sure. Yes, yes, of course we do this. When you know that the person has information, a chart somewhere there, you correspond, of course, with the permission of the patient that they're going to transfer this. They will sign a letter. Then you sign it, stamp it, send it over to the other clinic to say that, We need this information to be ... because we are sharing ... most of the time the patient ... I have patient with schizophrenia that they were living in Halifax back and forth in Guysborough County. So that happened to me that I had to ask

people who have been seeing them in Halifax to share with me what they have so far going on. So to be on same boat or same page to go ahead. Yes, I would do that, of course. That would help.

Q. Thank you, Doctor.

A. Thank you very much.

Can I plug in my computer? I think the battery is coming down a little.

THE COURT: Absolutely.

A. Okay.

THE COURT: I think there are only a couple more lawyers that may have questions for you. So your computer battery may outlive all the questions, but we'll see.

Mr. Rodgers?

A. Mm-hmm.

MR. RODGERS: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. RODGERS

(11:34)

MR. RODGERS: Good morning, Dr. Ali. Sorry, Dr. Khakpour. I'm from Guysborough. So I know you better as Dr. Ali, though I'm not sure if we've met.

A. Yeah, that's true.

Q. Doctor, I wanted to bring you back. Sorry, I'm the lawyer for Cassandra Desmond, who is the personal representative of Cpl. Lionel Desmond, her brother.

I wanted to bring you back, Doctor, to some of the earlier questions and comments you made relating to your upbringing and your early days as a physician in Iran. It strikes me, Doctor, that combat and war and the consequences, I guess both individually and as a society, would be much more of a direct part of life in Iran than certainly compared to Canada and particularly, maybe, Nova Scotia.

I wonder if you have any thoughts or observations on that distinction as it relates to soldiers with PTSD, something that you observed, whether it's, you know, in the preparation phase when the soldier is preparing for combat or in the treatment, if there's anything that, from your experience, you might be able to tell us about that.

A. So if I understand the question is that how it is different from like a Canadian condition back to my own experience when I was graduating out of the university?

Q. Yes, if there's anything that you ... any observations you have, or experiences that you have, Doctor, that might be

able to help inform this Inquiry of treatment of PTSD, prevention of PTSD, anything that you think might be of interest.

A. So what I have experienced over the ... as I explained to you, most of the time over there that's becoming a soldier in Iran is an obligation. So you don't have much choice to say, I don't want to. You wouldn't have any job earning ...

I think it's becoming just a little bit ...

Okay, so you don't have so much choice, and also, people have been living under tremendous stress. So I was a student. When I was in my dorm there was bombing on your head, above your head I mean. Then you would wait to see if the bomb is arriving at your dorm. You're going to be killed or you stay alive.

So I mean when you are coming from a condition and you are in the terrible country in war ... so people become a little bit more resistant to these stresses. So they become like ... I can't say stress-proof. They would have outcomes, but the setting would be different from here. So over there cultural matters helps to say that, You should be strong, you should not disclose your anger or frustration or depression, and they become kind of to the point they become explosive sometimes.

So the person does not show bad until really broken apart, really, and ... but in Canadian setting what I have seen, people would be more relaxed to explain to you what is going on on them because they are instructed that you should be yourself. You don't have any obligation to take this or that one. So army is something really different from what we have a daily living in the Canadian or North American structure.

So if the patient arrives and I say, You want to have an ultrasound? They say, I don't want to do it. So I have to think what else I can do for the person, because this much of choice is offered to the patient to choose. So when you are living like this and you arrive in a military service which everything is obligation ... you don't decide what to do or where to go and you are facing every minute dangerous things. So of course that's a far more different stress.

So my experience is that if somebody coming from kind of North America ... I mean I can even say Canadian because Canadian are calm, quiet comparing to our neighbour. So I ... that's why I'm here. I'm not in the US. So we choose to become Canadian, and I'm happy, I'm proud of it. What I'm saying is that in this setting which people are like relax, they choose what they want. It's like they're from cold ... hot touch. You

jump ... just jump into very cold water. So that kind of a stress.

The second thing is to me, I have seen people back home that they remain to the army service because they have financial conditions. So people who have been accepted to university or they finish and they had luck to be alive at the end of the two-year service. They would go to their job, what they were doing. But some people, because of financial conditions, have obligation to stay into the Service. So those people who choose to become military people because of their financial matters but never happy with their role. So they would be more agitated and under stress and, like, impulsive if something happens, because that was not their choice. That was forceful.

So again, these are factors that a person background why you stay ... if somebody wants to be kind of soldier that's happy with this role, this is good. But if somebody stays in the system with difficulty it would build up gradual discomfort and unhappiness.

(11:40)

So imagine that you are next to the ocean, beautiful trees. Now suddenly you are in a desert. Just you see the soil and you see people with a different language. You don't understand what

they say. And it's a life-threatening situation every day. So not easy. Especially you stay there seven months. I saw that he has been there in seven months.

So I would say long time staying in the battle zone far from family, absolutely different culture. All these things are added to the stress that Mr. Desmond and the community after this disaster suffered.

Q. Doctor, just in terms of Cpl. Desmond, and now further to what you were saying. You know, thinking of the comparison of the two cultures and countries, perhaps. Cpl. Desmond, would you agree, seemed willing to talk about what was wrong with him, you know, willing to seek help from your interactions with him?

A. So I saw him two times as you see on the notes. One was for his finger. Another time that he came to repeat the sleeping pill. No, he had a brief counteraction ... I mean interaction just to talk to me briefly. So I think if he had disclosed some information further in details with the nurses in, I don't know, St. Martha. That was because of setting. That was to discuss about the emotional state and the ... but he just was in the steady state and kind of not unstable to arrive to see me just to pick up the sleeping pill and go away.

That was why I didn't open the chart immediate, because he

didn't look to be anything wrong with him, just to have more indepth, I looked at it at the end of the day to see what has been going on with him.

Q. And, Doctor, did you get any sense from Cpl. Desmond of any hesitancy of dealing with you personally as an Arab man given his circumstances of coming back from combat in Afghanistan? Did you get any sense of that at all?

A. Mmm ... No, no, no, I don't think so. I don't think so because, you know, it is not religious combat to feel that somebody has a Muslin background - which I don't practice - or I'm a Christian so he's, what, different. No, that wasn't ... not such a thing. He was so welcoming and normal-looking. It was like every other patient that you meet in a grocery store to say, Hi, hello, how are you doing? Yeah, he is not just making joke or cheerful to be smiling but he's not also weeping.

So what I'm saying is that no, he didn't feel ... I feel that he was comfortable with me. Even ... well, personally I can say you can ask everybody living and have been there in Guysborough County. I have a very positive background. People would ... they're happy to work with me, so to come to see me. So I'm open-minded and I'm comfortable to talk of any issues even against their religion, whatever.

So he wouldn't have any problem and he was pretty good. And that was a shock when I heard that was because I didn't expect it, ever. When I heard it, it was ... even right now it cause me to ... it was difficult to understand that such a (inaudible - audio) unbelievable.

I think the (inaudible - audio) bit broken.

So I said that was absolutely a shock to me when I heard, because I didn't believe that that person would commit suicide and homicide like this.

Q. Dr. Ali, I could just say, I guess, as a comment that that was ... there is your reputation in Guysborough, and it remains so, of what you just said.

A. Thank you. I appreciate it.

Q. Dr. Ali, you alluded to this or started to talk about it, but I just wanted to ask you if you had any observations, you know, in the immediate aftermath of the tragedy, as you were still practicing and living in Guysborough, of the impact that this had on the community. If you're able to provide any comment on that.

A. So what I remember is that everyone was sad. Everyone was shocked. And I was thinking all the time about the remaining relatives because that is the aftermath problem that

would be surge of the depression and anxiety and that is another post-traumatic stress disorder to me, that wave that it spreads when the stone is thrown into the water.

So yeah, that was ... everyone was talking about this issue around and everyone was sad and, personally, I was really ... even right now when I talk it, and I talk to my friends that such a thing happened and it is just a shock that even not himself. It is another three people, especially the child is something. To me, it is completely ... the person would be out of control or whatever. I don't understand it, how I can describe it, for a child this age, especially your own child. This is something unbelievable. Should be tremendous amount of stress altogether building up, which is out of imagination.

Q. Dr. Ali, thank you for answering my questions. Those are all the questions I have. Thank you, Your Honour.

A. Thank you very much. Thank you.

THE COURT: Ms. MacGregor?

CROSS-EXAMINATION BY MS. MACGREGOR

(11:47)

MS. MACGREGOR: Good morning, Doctor. How are you?

A. Hello, Ms. MacGregor. Thank you very much. I'm fine.

DR. ALI KHAKPOUR, Cross-Examination by Ms. MacGregor

Q. I just have a few quick follow-up questions for you. I won't keep you long. One of the questions you were asked earlier by one of my friends was who your understanding of who the family physician was for Cpl. Desmond and you had said it was ... your understanding was it was Dr. Mahendrarajah. And am I correct in that you said that was your understanding because you just simply saw her name on the emergency records?

A. Yes.

Q. Right. Okay. And then I think you clarified this but I just want to close the loop a bit. Earlier Mr. Russell had asked you about the name of the system the clinic had for accessing charts, and I know Mr. Rogers asked you some questions about that as well. And I just want to make sure. That was ... at the time it was Nightingale was the EMR that the clinic used?

A. Yes.

Q. Okay.

A. That's true, yeah. That was Nightingale.

Q. You were also asked about access to records and you talked about, you know, some of the physicians in the clinic kept their EMR on the computer system and then Dr. Mahendrarajah kept hers in the paper copy. But I'm correct, am I, that if you wanted to see those records you just would get the file which

was placed outside the door while you were seeing the patient?

A. Yes, if needed, yes. You can ask for the previous paper chart.

Q. Okay.

A. They will present it to you. You're right. It is accessible, yeah.

Q. Okay. And then a few moments ago my friend also asked you about Dr. Slayter's December 2 report. That's at page 13 of the documents, and you were referred to that last paragraph where Dr. Slayter said he would follow up for a few more visits. I think the wording was, He would follow him for a short while to help him get connected. And is it correct that when you saw Cpl. Desmond on December 20th and he told you he had an appointment the next day with Dr. Slayter that you assumed, I guess, that was part of the follow-up that Dr. Slayter was planning to do?

A. Absolutely, yes, because as he left I checked his file and I see that things has been checked, set up, and Dr. Slayter has seen the patient. That was peace of mind that psychiatrist has checked my patient that I am seeing on the office on that day and then he says that he going to see. That means that yes, that is what he says that I'm going to follow up the patient.

Exactly true.

Q. Okay. Thank you, Dr. Khakpour. Those are my questions. Thank you for your time.

A. Thank you very much. Thank you very much.

THE COURT: Mr. Russell, do you have any further questions for Dr. Ali?

MR. RUSSELL: Nothing on re-direct, Your Honour.

THE COURT: All right. Thank you. Dr. Ali, I think that, that would conclude the questions from counsel this morning. I don't have any particular questions. I would like to thank you for your time. I know that you have spent some time with the clerks to make certain that the link worked well, and it was pretty efficient today for most purposes. And I know you took time to review the medical notes and the charts to prepare for the questioning today. Your time is important to us - I know it's important to you - and we appreciate the effort you put into provide us with the information. It's important for us to have to fully understand all of the events that occurred as they relate to Cpl. Desmond. So thank you very much for your time, Doctor.

A. Thank you very much, Your Honour. Thank you very much everyone present in the room. I'm so sorry what all this happen

to Mr. Desmond and my heart goes with the family. Although maybe we didn't have time to have a kind of ... announce this feeling, but I hope things like this would not ever happen to any Canadian soldier. Or even other countries. It doesn't matter. That was a sad ending. And I appreciate all the efforts that have been done to shed light on this to find what is going on to avoid such a disaster happen again.

Thank you very much, Your Honour, and any more question? Or we are done?

THE COURT: No, I think we're good for the day. Thank you once again for your time, Dr. Ali. Stay well. Thank you.

A. Thank you very much.

WITNESS WITHDREW (11:51 HRS.)

THE COURT: Counsel, we'll adjourn to 1:30 unless there's anything you want to discuss. No? All right. Thank you.

COURT RECESSED (11:51 HRS.)

COURT RESUMED (13:31 HRS.)

THE COURT: Mr. Murray? Mr. Russell?

MR. RUSSELL: Yes, Your Honour. Dr. Harnish, I believe, is present in the courtroom.

THE COURT: All right, thank you.

Dr. Harnish, could you come forward, please? No one showed you how, you just have to cross behind the last row of counsel there, that will get to this spot over here.

DR. LUKE HARNISH, affirmed, testified:

THE COURT: Have a seat, Doctor.

A. Thanks.

THE COURT: Thank you.

Dr. Harnish, just before we begin I can tell you a little bit about the courtroom and the setup that we have here. We are able to sit because the Public Health officials have had a look at our court and our setup and they told us that we are consistent with all the Public Health protocols. As well, that would allow you to remove your mask if you are comfortable removing your mask for the purposes of testimony. The rule that we have in effect here is that you come in wearing a mask, when you move about the courtroom in any particular way you wear a mask, and once you're seated in place you're permitted to remove it.

A. Okay.

THE COURT: I know you brought a bottle of water but I can tell you that the other bottle of water that's there is still sealed and that's for your purposes as well.

A. Okay, thank you.

THE COURT: All right, thank you. Mr. Russell?

DIRECT EXAMINATION

MR. RUSSELL: Good afternoon, Dr. Harnish.

A. Hello.

Q. I thank you for coming here in person. It's nice to have a live witness, I guess, in person for a change.

So, Doctor, I wonder if you could tell us your full name for the Court?

A. Sure, my name is Luke Alexander Harnish.

Q. And I understand you're a physician, Dr. Harnish?

A. I am.

Q. And how many years have you been a practicing physician?

A. I'm coming up on seven.

Q. And in the seven years were they all spent in this province, in Nova Scotia?

A. No, I also hold licences in Northwest Territories and Nunavut.

Q. In Northwest Territories and Nunavut?

A. That's correct.

Q. I wonder if you could tell us a little bit about what drew you to Nunavut, to Northwest Territories, and when was

that?

A. In medical school I did an elective in Inuvik in Northwest Territories and since then I've had a desire to go back and before the pandemic would probably spend between eight and 12 weeks a year between the two.

Q. So each year would be sort of a recurring ...

A. Locum opportunities, yes.

Q. And you would go back year-to-year?

A. Mm-hmm, wherever their needs may be.

Q. So assuming we get through this pandemic, is your plan to continue with that locum?

A. If my wife would continue me to keep going I probably would.

Q. So are there any sort of differences, I guess, in your experience in practicing medicine in one of the territories compared to, say, Nova Scotia?

A. Oh yes, there's many differences. It's quite remote so it presents it's own unique challenges for sure.

Q. And can you give us a few examples?

A. I've been in probably the most isolated place in Canada and had to wait ten hours for an airplane to come and pick somebody up to fly them ten hours further south to get care

that should have been immediate so those are common occurrences.

Q. Sounds enjoyable.

A. It can be stressful.

Q. Yeah. And so how many years in total have you ... you said you were a physician?

A. I graduated my final year in residency in 2014 in July so I'm in six and a half years basically now.

Q. And has it always been in general family medicine?

A. I primarily nowadays practice emergency medicine.

Q. And so emergency medicine, you work in an ER sitting I take it?

A. That's correct, yeah.

Q. What sort of special training did you have or I'm assuming you had to undergo some special training to be able to practice emergency medicine?

A. I have. Not all emergency physicians necessarily have. I completed a two-year family medicine residency program and then followed up with an additional year of training in what's called special competency of emergency medicine.

Q. And when did you complete that training.

A. 2014.

Q. So what is it, in particular, that sort of requires

special training to be able to practice in the ER setting?

A. Well, not all emergency physicians do. They may be there with only family medicine training but the extra year just gives you more kind of confidence in skills in practicing in Emerg.

Q. So what sort of skills? Can you give us some examples of ...

A. Well more confidence with airways, intubations, challenging, crashing patients, you know, different procedures and skills. There was a lot of time spent in the ICU during that year. On cardiac floors and cardiac ICUs so ... and anaesthesia and airway practice like I said.

Q. So, in particular, as it relates to mental health, so I take it in your general family practice you would have had numerous clients present to you in some form of either mental health crisis or struggling with their mental health?

A. Oh absolutely, yes.

Q. And as well in an ER setting?

A. It does happen, yes.

Q. So in your extra training to work in an ER setting, the training that you did, were there any components about patients who present themselves in mental health in a form of

crisis as it relates to their mental health?

A. I mean, there wasn't a specific psychiatry unit I don't believe in that year. There were in family medicine and medical school training but, you know, it's a common enough occurrence that when you're in the emergency setting you do have exposure to that as well.

Q. And in your experience, is there any sort of subtle differences in the experience or the approach as an ER physician dealing with a patient that presents in a form of mental health crisis or with a mental health-related complaint versus in the family practice in your office?

A. You know, often you might see someone in crisis more likely in the emergency department, that's often where people are instructed to present. In the family medicine center you may know your patient well and know their background a bit better and so have a better understanding who they are as a person from the get-go.

Q. So I guess you're a little more familiar with the patient as a rule in family practice as opposed to ...

A. A family physician would generally know their patient, yeah.

Q. So how is the approach, I guess, a little different?

So in an ER setting, someone presents to you maybe for the first time indicating that they're depressed, anxiety, they disclose to you a number of life stressors and you're not familiar with their background as opposed to a patient you've seen a couple years throughout your family practice. Is your approach any different and, if so, how?

(13:40)

A. It all depends on the degree of severity of their symptoms at the time I suppose. If it's sort of general run-of-the mill depression, that would be the same approach. If they're in an acute crisis and don't know where to turn or feeling suicidal then I suppose the access to care may come ... or sorry, the degree of what you do about that might be more immediate.

Q. I'd like you ask you a little bit about, maybe to me it seems to be still a little bit of a mystery in the sense of when you're taking the approach of assessing a patient for suicidal ideation or suicidal risk, homicidal ideation, homicidal risk, is there any particular tests that you apply or how do you go about assessing that?

A. Sure. I mean, generally with any mental health complaint it's at least addressed to some degree. Depending on

how in depth and how structured that is is really dependent on the actual situation at hand, they can be very different. So there are different tools and assessment models that do exist. I don't typically employ a structured, Here fill out this form approach but it's sort of a hybrid of different risk factors, different acute stressors that might be going on and to get a general picture of what this person's current in-the-moment risk might be.

Q. We've heard from, I don't know if you're familiar with Dr. Slayter, he's a psychiatrist at St. Martha's.

A. Okay, yeah.

Q. And we've heard from Dr. Slayter about various tools for suicide risk assessment and the various portions of those tools. Are you familiar with those types of checklists and tools?

A. Oh yes. Yes.

Q. And where would you have sort of learned about those tools? Is it through your practice or are you taught those?

A. You're taught those to some degree in your initial psychiatric units in medical school. There's many different models that different practitioners may or may not use so there's no like necessarily definitive one that is the

recommended one and then you're kind of exposed to them as they come up or cases may present.

Q. So do you find them, as a rule, helpful or practical?

A. Certain tools sometimes are helpful or calculators but, you know, when you're in front of a patient and you pull out a form and go through the checklist sometimes that doesn't necessarily help establish the best rapport with patients or the most like genuine interaction with a human, so it can be kind of artificial. So I try to have a more personal approach with people.

Q. And so I'm trying to reconcile, you know, ideally you would like an assessment for suicide risk or homicidal risk to be very scientific in the sense of if you score an eight out of ten it therefore equals but I get the sense it's assessing suicide risk or homicide risk is not as simple as that?

A. It would be nice if it was but, yeah, you don't always know exactly what's going on in somebody's head but these tools do help establish a more, I guess, objective way of measuring that. They often do employ a long time to conduct so there's often not enough time to really thoroughly go through a full tool maybe in the emergency setting or in the family medicine practice compared to maybe the psychiatric world where they have

a lot more time to deal with people.

Q. So I should maybe distinguish, I've been referring to both at the same time, suicide risk assessment and homicide risk assessment. You know, they are two different things but are there different ... are you aware of any tests for homicidal ideation and risk separate and apart from suicide?

A. No, generally they have been lumped in together sort of in the training.

Q. So it's not a check for one and then a check for another, it's sort of ...

A. At the same time.

Q. ... at the same time? In terms of when you're doing a suicide risk assessment which factors in homicide risk assessment, we've heard a lot about a physician might come right out and ask the patient, Do you have thoughts of self-harm and have you acted on those thoughts, very direct sort of questions. Is it fair to say that when you're conducting that risk assessment it's highly dependent on the information that the patient in front of you is giving you?

A. Well yes, there's like social cues and different ways that they are presenting so not necessarily verbal things that they're telling you but there are social or physical ways they

may be behaving that can guide you. And then with each individual encounter, the degree of how you approach the suicide questions can vary so if you want to maybe start more open ended and ask about if they're having any feelings of not wanting to wake up in the morning, feelings of self harm, and then gradually build into that or be more pointed and direct and I've employed both.

Q. Did you ever have sort of a situation where you're assessing for suicidal risk and homicidal risk, you're getting a narrative from a patient, but you're thinking well, I would like sort of a collateral, a corroborating sort of evidence I guess to use a legal phrase. You would like to see information outside of the patient to see whether or not it supports the accuracy of the narrative that they're giving you?

A. Yeah, I suppose that has come up.

Q. And have you seen that sort of in your own practice when you were doing those assessments?

A. I'm sorry?

Q. For example, you have a patient that's giving you a narrative when you're navigating the risk assessment and perhaps there's something you're not sure of. Whether or not they're being truthful or whether or not they're just simply unable to

be accurate.

A. Mm-hmm.

Q. Are there things that you've actually looked for to see if it supports that narrative?

A. Oh yes, you can go back on certain medical records to look to see if there's anything else there.

Q. And have you done that?

A. Yeah.

Q. So I wonder, obviously don't breach any patient confidentiality, but can you think of an example of where you might have applied that in practice where somebody is ... you're trying to assess risk and they disclose information to you and you went, You know what, I'd like to check another source to sort of verify this?

A. Oh, it's pretty common. I don't know if I need a specific example to answer that, but in the emergency world, for instance, in Nova Scotia we use a system called MEDITECH in most of the province and I quite frequently look for collateral history there when it's not immediately available with a family member or somebody in the room. So in Emerg you'd have to do that either before or after an encounter with a patient, not right in the room at the same time with them, but you can go on

and look for different discharge diagnoses or other sometimes mental health visits as well.

Q. So when you're sort of dealing with a patient in some form of mental health distress, is it fair to say that quite often it's important perhaps to have, if there's a documented medical history that you have and you can take a quick look at that?

A. Absolutely. I would, you know, in the emergency room there is a triage note you read before you go in to see a patient. So often I spend some time before even entering the room researching what I can to get to know the patient first.

Q. So I'm just going to ask you a little bit about your time, before we move to Lionel Desmond directly ...

A. Sure.

Q. ... just a little bit about your time in the Guysborough clinic.

A. Clinic, yeah.

Q. Clinic. Did you also spend time in the Guysborough ER?

A. Yes. So my experience in Guysborough was as a locum physician so I was covering for one of the family doctors in Guysborough and I think I've done maybe four or five locums

there, I can't recall, in total maybe four to five days at a time per stint and during that time I would spend maybe half of the time covering the Emerg and other days only doing clinic and the days that you were covering Emerg you were also in clinic and would be called to Emerg if an emergency presented during daytime hours and then you'd be on call at nighttime.

Q. So sometimes I guess your day would be a hybrid of both ...

A. Yes, that's right.

Q. ... you're covering both the ER and scheduled appointments?

A. Correct.

Q. Did that get interesting from time to time with patients going in two different ...

A. In smaller rural settings like that it can seem like probably it could but it often, in my experience, hadn't been that much of an issue. Most patients in the clinic are low acuity so understanding that if you get called to Emerg then it's necessary that you go and access to care is generally fairly easy in Guysborough, I think, so there is a certain understanding that if they had to wait a long time perhaps that they could re-book.

Q. So how many ... do you currently still do locums in Guysborough?

(13:50)

A. No, I haven't probably I think maybe in two years.

Q. What was the period of time in which you were doing locums in Guysborough, so do you recall what years?

A. No, I can't recall exactly but I would estimate probably 2015 to 2018 would be a good guess.

Q. I'm just going to ask you a little bit and we've been asking the physicians that operated in the Guysborough clinic a general sense of how the structure of that clinic operated. So from your perspective as a locum physician, would you ever consider yourself as the family physician for a particular patient that might have saw you on a certain day?

A. On that particular day, sure yeah, but under like the idea of me being sort of like the substitute teacher for the class that I was there for a day or two to cover while this other physician was away so I was acting as their family physician that day.

Q. So, for example, if you were filling in in the Guysborough clinic on a particular date, there was a new patient, someone that maybe had never been seen at that

particular clinic before and a mental health-related series of concerns that they wanted to navigate through and they needed potential follow up, whether it was contact with a social worker or psychiatry, psychologist, would you be the one that would start making those referrals?

A. If they were necessary I could, yes.

Q. Would there ever be a scenario where there would be a hand off where you would say, I saw patient X on a Monday, my initial impressions are depression, anxiety, could be bipolar disorder, needs further follow up with a psychiatrist. Would you ever leave that to another physician, whether it would be Dr. Ranjini or Dr. Ali who were there as well or would you take care of that yourself?

A. Well, it depends I guess. I mean if the referrals needed to be made on a specific day and I was the attending physician then I would make them but I generally would write in a note, a plan going forward of what I think might occur or might need to happen in the future just so it can be easier for them to understand what was going on the day that they weren't there.

Q. How was the sort of record sharing and record system at the Guysborough clinic?

A. At the time they were using a program, an electronic medical record I should say, called Nightingale which was, at the time, very commonly used throughout the province, I was familiar with the program. It's since I think no longer ... it's no longer in use anymore, the company has transitioned or I don't know exactly what happened with Nightingale but it's not around anymore. And Dr. Ranjini, if I remember correctly, would also use paper charts.

Q. So how many different sort of, I guess, clinics or ERs would you estimate that you've practiced at throughout the province?

A. Probably ... I've even worked in Port Hawkesbury actually here. Six perhaps, seven maybe.

Q. And in terms of accessing records, did they all use Nightingale?

A. No, not necessarily and we're talking about two different kind of scenarios here. Are you talking about the family medicine world or the emergency world because they are different?

Q. I guess we'll start with the emergency medicine world.

A. Sure. So in most of Nova Scotia, HRM and the IWK being kind of excluded, a program, a provincial-wide program is

used called MEDITECH and if you have access to MEDITECH you can see anything throughout the province on a patient that has been uploaded to MEDITECH. So on a day-to-day basis, practicing outside of HRM or the IWK, that would be the program that you would access. There's other programs that you do use to look up imaging, for example, that's a provincial-wide one but only within hospitals, not in family clinics. There's a way to get information in the hospitals but not in family clinics that can give you some information from the hospitals in Halifax. The IWK is very challenging to get information from, it's basically an island amongst the province.

Q. And I understand that they're their own separate entity from the Nova Scotia Health Authority?

A. Completely separate, that's right.

Q. So when you say it's a different island to get information from what do you mean?

A. I can remember examples where I've needed, in the emergency department, sort of like important timely information from a visit that a patient had had just a few days prior.

Q. At the IWK?

A. At the IWK and I couldn't get it easily at all I think which hindered care I suppose.

Q. So in your experience of going through, we'll start in an ER setting, was it fair to say that there were different programs depending on the ER in which you were at?

A. No, most emergency departments by far and away use MEDITECH throughout the province and I'm very comfortable with that program and it's familiar and useful wherever I am that uses it.

In Halifax and the IWK it's just a separate program. I can access the Halifax programs through a program that's web based or web browser based called SHARE and I often do use that as well.

Q. So I guess in your experience, is there one program that you think is superior to the other? Is it the Halifax program versus what was offered in Guysborough or ...

A. I don't know, I think just it doesn't ... the program is the program, it's just the one that you use so the one I'm more comfortable with because I use it more frequently would be MEDITECH, I'd use it also in Nunavut, so I'm quite familiar with it so it's not that one's better than the other.

Q. And in your experience, have these programs given you access to the information you needed or were there times where items were absent?

A. Oh, I mean, there are certainly times when items can be absent or incomplete or just not uploaded yet and there can be various reasons why that might occur.

Q. And did you get a ... in your experience, has that sort of hindered or slowed down your ability to treat patients?

A. Sometimes it can, yes.

Q. And in what way?

A. You're just sort of ... often, you know, if someone has seen a specialist, for example, there'll be discharge instructions of like this is my impression and plan and so you can turn to those to look for the scope of where you should start or where you should go from as a starting point so if they're not there and they had just seen this physician and then they're coming to see you in follow up and they're not there, then there's not much you can do about it until you have that information.

Q. So you've had the experience where it would have been helpful to know the plan but it was absent ...

A. That's correct.

Q. ... from where you're looking?

A. That's right.

Q. And in terms of family practice, I understand that

that's quite a little bit different as well.

A. That is.

Q. If you could tell us about sort of the record keeping systems in a family scenario.

A. Sure. You know, there's a bit of a history, I guess, about how that's evolved. I've only been practicing in the world where EMRs have been generally the standard but there are some physicians who are still practicing with paper charts which was the standard before EMRs came onboard.

And in the family settings, you know, in the past, like I said, Nightingale had tended to be one of the more popular EMRs. There are several different programs that you can choose from and there's pretty much, I think, two that the province is using now in most family clinics. And then access to medical records in the family clinic, you're often not able to access the same hospital-based programs because they're not held on the same server so you can't access that information, it's guarded information for patient confidentiality reasons.

So typically if you're a family physician, you're assigned to that patient, any kind of label that's printed would have that family physician highlighted on the chart so if you're seeing a specialist or an outpatient clinic then a copy of that

report would be forwarded either electronically or faxed to the family physician's office so that they could upload it to their own system.

Q. So, for example, where is your current family practice, do you have one?

A. I do not have one.

(14:00)

Q. You do not have one, okay. So if you were currently practicing family medicine let's just say in Port Hawkesbury.

A. Sure.

Q. And you have a patient that you see on a regular basis. Last Friday that patient attended the ER in Halifax, depressed, anxiety, number of life stressors, not enough to be sort of held overnight, there wasn't a decision to make them held overnight, but they were treated and ultimately discharged. You as a family physician, would you get alerted to that ER visit?

A. Yeah, I mean, they typically will get a copy of the note that is made in Emerg and they'll see any bloodwork or imaging tests or anything that had been done that will just generally automatically populate onto their own EMR, it'll just be instantaneously there, you can sometimes tell when someone's

in the emergency department.

Q. So does it go into your system that you can access as a family physician?

A. Yeah.

Q. What if a scenario where it's a shared clinic, for example, like Guysborough where multiple physicians are treating the same patient and the same scenario, they appeared in Halifax last Friday, would all physicians in that clinic, Guysborough clinic, get an alert to that?

A. Yes, I presume they would or it would be populated on the EMR. Probably it would go to actually, sorry, whoever the ... I believe in Guysborough the specific family physician is. They may all use the same program but that individual family physician would get an alert or that something has been uploaded to their document section and they would see it there. So not all would necessarily see it.

Q. What about if, for example, the patient wasn't your regular patient but just came in, would you have access to that information?

A. Yeah, for sure. I mean, if you happened to be the one seeing them then you would open their chart electronically and all that information would just be there.

Q. Have you seen scenarios where there's been a delay in sending the chart?

A. Yes.

Q. Where it hasn't necessarily been instantaneous?

A. Absolutely.

Q. And what are some examples of delays that you've seen, how long?

A. I think it varies but it has ... there's many factors. Most physicians in the speciality world will dictate a note and they'll speak that into a phone, then a transcribist has to transcribe that note, and then they get sent back to that physician who has to sign off that this is okay, I accept this note, and then it would be sent out and sometimes there's just, you know, maybe overburdened physicians or whatnot that they will delay their time to get to actually dictating that note so sometimes you wait for the note.

Q. And I understand when we're talking about access to records, the simple example that we seem to use is access to records that happen at a hospital, a Nova Scotia Health Authority hospital in Nova Scotia. What if it was an individual that was seeking sort of a private clinician, say Dr. Slayter has his own clinic separate and apart from an ER setting in the

hospital?

A. So typically in at least the emergency world you would never have access to those, they wouldn't get uploaded to MEDITECH. In the family medicine world it's difficult to know if you would have necessarily those records unless some may send it to the family doctor and others may not.

Q. What about someone, for example, like Lionel Desmond who had been spending time between provinces. Would you, as a rule, have access to health care records from another adjacent province like New Brunswick?

A. No.

Q. What about someone like Lionel Desmond who has, we know he has a long history of medical professionals that interacted with him, would you have had access to Canadian Forces medical records?

A. No.

Q. What about records from when he was discharged from the miliary, Veterans Affairs Canada, he's involved with an OSI clinic in New Brunswick, would you have access to those?

A. I can tell you from Mr. Desmond's case, no, there were no records there. I don't know if that would be typical for OSI or Veterans Affairs to send them to ... as part of their care as

I have not encountered that in my practice.

Q. So as a general rule, have you seen many sort of military veterans in your practice?

A. Not that many that I'm aware of. I don't always know if someone has a military background.

Q. Okay. So if we could look at, I'm just ... and it'll come up on the screen, Doctor, and if you need a paper copy just let me know but as a rule it will come up on the screen in front of you.

A. Okay.

Q. It's Exhibit 92. This is going to be the Guysborough records.

A. Okay.

Q. And we're going to look at page 7. Can you see that okay in front of you, Doctor?

A. I can. I can't quite see the bottom of the note but most of it there.

Q. Okay. If we get to that part we can scroll it up for you and if, at any point, there's something on the document that you want to reference just let us know.

THE COURT: Or when a document comes up, Dr. Harnish, if you see ... if you want to kind of orientate yourself and have a

look at the entire document, just let us know and it'll get enlarged and scrolled in such a way that you can actually look at the whole document if you need to orientate yourself.

A. I won't touch the screen.

THE COURT: Well, you can touch the screen but it gets scrolled from over here. But if you actually want a paper copy, we'll get you a paper copy, too, if it's easier for you to look at it that way.

MR. RUSSELL: So, Doctor, at the very bottom it shows signed off October 13, 2016, and at the top right-hand corner it says "Visit Date - Thursday, October 13, 2016" and I'm assuming you recognize this note?

A. Yes, I do.

Q. And generally what is it?

A. This is the note I would have written after seeing Mr. Desmond in clinic.

Q. On October 13th?

A. That's correct.

Q. Would this have been the first time you would have seen Lionel Desmond?

A. Yes.

Q. And prior to that date did you have any previous

knowledge of Lionel Desmond at all?

A. No.

Q. And would you have seen Lionel Desmond any time after October 13th?

A. I don't believe so.

Q. So, Doctor, I'm wondering, this note, do you recall on this date how you came to meet Lionel Desmond? Was it in an ER setting or was it in the clinic setting?

A. It was the clinic setting.

Q. So 2016 that would have put you at a time where you were doing locums at the Guysborough clinic?

A. That's correct.

Q. I'm wondering if you could just indicate to us what was the purpose of Lionel Desmond's visit to the clinic to see you on that day?

A. From what I can remember and reviewing my note, he was coming back from being away and was basically there seeking or wondering what his follow-up plan was going to be coming out of the Ste. Anne's Hospital in Quebec.

Q. So when ... and do you recall if he was by himself that day? Was he accompanied by anyone?

A. He was present with his wife.

Q. Okay. So they were both in the office with you?

A. They both were.

Q. So I'm wondering if you could indicate, and we'll get into what he was wondering and about the plan momentarily, but did he indicate to you whether or not he was struggling with anything or he was having some concerns whether physical or mental health related?

A. I mean we did talk about certain things like that but the overall kind of, I think, feel for the appointment was just sort of wondering what his next steps were to be.

Q. And he was coming in to see you to find out what the next steps were?

A. Well, he didn't, I think, know what the plan was and didn't know where else to turn, I think, at that point so he came in to see if we could help him.

Q. And was his wife, what you recall, was she sort of much the same, sort of wondering what's the plan?

A. I think they were ... yeah, I think that's fair to say.

Q. So I just want to be clear of sort of the overall, your understanding of the purpose of him coming to see you at the Guysborough clinic on this day. Was it in relation to any

sort of physical ailment? Did he say, Look, I have a bad back, I have sore legs, this is why I'm seeing you?

A. No.

Q. Did he make the point ... appointment, I appreciate you can't say why he made the appointment, but your impression, did he come in and say, Doctor, look I'm struggling with anxiety, I need a refill on my medication, I'd like to talk to you about this?

(14:10)

A. No, I think they just were trying to reestablish themselves back in the Guysborough community and also knew that he had, you know, come out of this program in Quebec and had the impression that there was more to come and had, at that point, not heard anything so was wondering what to do next.

Q. Do you typically encounter that in a family clinic setting where a patient comes in to you and they say, Look, I'm not actively looking for necessarily you to take a look at my arm or my leg or can you help me with my anxiety directly as opposed to ...

A. Facilitating different things?

Q. Yeah.

A. Yeah, for sure, that's very common. So often you see

people coming in to get results from imaging tests and you just go over the results and sometimes there's recommendations from those that say you should go on and have this test or this done and then we organize that at that time or likewise, I've just seen a specialist and they're coming back to sort of employ their recommendations.

Q. So in his case did you get a sense of he was looking for you to review any particular chart?

A. I think they were just again trying to figure out what the next steps were going to be coming out of Ste. Anne.

Q. Do you recall if he had mentioned that he had been at the clinic previously or before or he encountered another doctor at the clinic?

A. All I kind of remember is, you know, he would have just been a patient in the middle of my schedule that day so I may have had a few minutes before the day started or just before seeing him to look up his chart and I honestly don't remember that there was anything on the chart. I think there may have been one Emerg visit that was I think was the bee sting actually.

Q. And so ...

A. That was the only thing that was in his chart.

Q. So you recall at that day you went and said, I'm going to look at his chart to see what sort of history he has with this clinic and ...

A. Or anywhere else but there was just nothing there.

Q. And you said it was maybe one note about a bee sting?

A. I mean, I only ... I think I remember that, yes.

Q. Okay.

A. Yeah.

Q. But it wasn't really relevant to ...

A. No.

Q. ... I guess bee stings are only relevant ...

A. Yeah, a bee sting is a bee sting.

Q. Okay. So he discloses to you, I guess when we look at the first line: Recently moved back to Guysborough after being away for approximately 11 years and you note he was there with his wife today. Did you get any sense of where he had been for the last 11 years?

A. I don't think we really probed into specifics of where, I assumed it was in the military and then most recently at the hospital in Quebec.

Q. And so he was the one, and I'm going to look four lines down, you note: "He reports that he was discharged at some

point due to depression, stress, and PTSD." When you say discharged at some point, did you understand where he was discharged from?

A. I believe it was the military.

Q. So at this point you're sort of trying to get some information about him and his military service?

A. If I recall, it's what he's offering to me just to give me his background.

Q. And he indicates depression, stress, and PTSD?

A. Mm-hmm.

Q. And did you ask him about being admitted to what you have referred to as the military hospital in Montreal, Ste. Anne's, for three months? Did you probe that information or is that information he volunteered to you?

A. That's what he volunteered to me.

Q. Do you recall what he told you or why he was at Ste. Anne's?

A. Yeah, I think I wrote in my note he received the targeted counseling and therapy and different medications in an effort to help curb his memory of his nightmares.

Q. Okay. When you say to "curb his memory of his nightmares", what do you mean by that, this is reported from

him?

A. That's right, that's what he said was the goal of his therapy at that hospital.

Q. To get rid of his memory of his nightmares?

A. Well, I think I said in my notes somewhere here, where is it, it says: "... the goal of his treatment was not to decrease the frequency of dreams but to rather decrease his ability to remember them".

Q. And you noted that he received targeted counseling and therapy as well as medications and symptoms were under control. Do you know what sort of targeted counseling or targeted treatment he would have received?

A. I can't say I know.

Q. And was he able to articulate that to you or his wife?

A. I think it was ... that was the degree of their articulation.

Q. You indicated: "He was discharged and subsequently moved back to Nova Scotia." Were you able to get a sense of the status of his relationship with his wife? Did they get into that as to ...

A. We didn't discuss their relationship at all. I got the impression that she was very supportive and engaging and

caring for him. She was very upbeat, I remember, in the appointment.

Q. And I guess in the first paragraph, the second last line I'm going to read it in, this is your note: "He believes they were supposed to set up FU." Is that follow-up?

A. That's correct.

Q. So: "He believes they were supposed to set up follow-up in Nova Scotia, however so far has received none." So tell us a little bit about that conversation that you recall, who was the person that was supposed to, according to him, set up follow-up?

A. I think that was the main purpose of, again, why he was there that day, to figure out what but I believe "they" means the discharge instructions from the Ste. Anne Hospital.

Q. So he was ... and you said "so far has received none". Was it him that's telling you that, Look, he hasn't received ... I haven't received any follow-up?

A. That's right.

Q. Were you able to confirm, in any capacity, what, if anything, was happening with his treatment since he was discharged from Ste. Anne's?

A. I got the impression that he was sort of in a limbo

period.

Q. Was there anywhere where you could look to see where he was in terms of treatment after he left?

A. No, there were no records that I had access to.

Q. And Shanna Desmond, did she seem to be able to offer any further insight? So he's wondering, you know, he's asking you they were ... he's saying to you they're supposed to follow up, I haven't received any. Did she seem to know more information than him or was she ...

A. No, I think they were both wondering what was going to happen next.

Q. And then you noted at that second last line: "He has been home for two months and does not have a copy of his chart to verify treatment, diagnosis, and plan." Tell us a little bit about that note that you made.

A. I think that's probably me writing that, I mean, knowing in my note that I don't have it here on his chart and also stating that he personally doesn't have a copy of it as well.

Q. So at this stage you're in the role of, I guess, family practitioner or family physician, he's your patient at this time, he's presented to you not specifically as it relates

to any sort of illness or particular trauma or crisis but he's presented to you as sort of, I don't know where to look and where to turn but it's important that I do and I'd like you to help me.

A. Mm-hmm.

Q. From your perspective, what is your role at that point?

A. I think the way we looked at it was, Let's try to facilitate getting this plan so that we can get that plan in action.

Q. And from your perspective as the treating doctor at that point, he's indicated to you that he has a history of depression, stress, PTSD, I'm mindful of the fact that you don't know the whole history of it. He's indicated to you that he's been in a residential treatment program, he's a military veteran. Those three sort of concepts packaged together, is it saying anything to you about his significance and importance of follow-up?

A. I think for Mr. Desmond he was showing, you know, willingness to engage in this follow-up, that's why he was there so I think that's a positive, it's a forward thinking kind of thing to want to engage and he was there. I wouldn't know, I

can't remember if he was frustrated or just kind of waiting, he didn't know how long it would be until these things were going to happen, he just didn't know.

Q. So at that point what did you know about Ste. Anne's, the hospital?

A. Nothing.

Q. So did you know that Ste. Anne's was a specialized treatment program for military veterans?

A. I wouldn't have known that, no.

Q. And during your visit with Lionel Desmond are you trying to find out what this place was, what did it involve?

A. Well, I mean, from whatever he told me that it was a military hospital for ... and it had a special PTSD program. What the details of what goes on in that hospital he wasn't able to really express to me.

(14:20)

Q. And I understand that it's not ... you're familiar with Google?

A. That's right.

Q. And you're familiar with the internet?

A. Quite.

Q. And at some point during your meeting with Lionel

Desmond and his wife do you end up finding yourself going on the internet?

A. Yeah, so we got to the point where we said, We need to find these records for you. So we ended up, the three of us, Googling the Ste. Anne hospital to get their phone number and they were able to confirm that that was the correct hospital so we got what information we could and then I think Mr. Desmond offered, I believe it's called a military service number, I could be wrong with that terminology but we wrote that down and had our front desk people inquire about obtaining the records.

I think I would have told him that, you know, there would be a process of, you know, releasing the information, consent would have to most likely be given, they were aware of that.

Q. In terms of Nova Scotia in 2016, it's at the very early stages but an operational stress injury clinic existed in Halifax that received referrals as it relates to members of the RCMP and military veterans. Were you familiar with the OSI clinic at that time?

A. No, I was not.

Q. Did you even know it existed?

A. I did not.

Q. Did you have any knowledge that there was a discussion

to maybe have Lionel Desmond referred to that clinic?

A. No.

Q. And did Lionel Desmond or Shanna Desmond indicate that to you at any point?

A. I don't believe so.

Q. So in addition to Ste. Anne's, we know he spent some considerable time, over a year, affiliated with an OSI clinic in New Brunswick. Did you know anything about that?

A. No, just the Ste. Anne Hospital.

Q. And so now we know that you're on Google looking up phone numbers for Ste. Anne's. In your search of Google did it show an image of the hospital?

A. Yeah, I believe it did, yeah.

Q. And how did you get Lionel Desmond and his wife maybe to verify that's the place?

A. With that image and I think the location and the address they probably knew it.

Q. So just so I have this right, so you're sitting in your office with a military veteran who is looking for help and you're showing him pictures of the hospital that you think he might have attended?

A. That's right.

Q. Do you think it would have been more helpful for you if there was any sort of system in place where you would have been able to look over here or had a number or a person to call as it relates to your military veteran, I know who to contact?

A. Absolutely, that would have been more beneficial.

Q. And why would that have been more beneficial?

A. Well, it probably would have been more streamlined and we were just sort of grasping at straws of trying to figure out where to go next so that was the only place we had to go at that point.

Q. Did you know anything about Lionel Desmond in terms of that he had a Veterans Affairs case manager?

A. I did not.

Q. Doctor, today do you know what a Veterans Affairs case manager is?

A. I do now, yeah.

Q. At the time did you have any idea of what a veterans case manager was?

A. I don't think I would have known enough to know ... assume that he would have had one at the time.

Q. If you had known that there was a Veterans Affairs case manager that was gathering information from Quebec, from a

clinic in New Brunswick, and speaking to an OSI clinic in Nova Scotia about how to navigate Lionel Desmond's treatment going forward, would you have spoken to that person if you knew they existed?

A. Absolutely, yes.

Q. And I appreciate that perhaps it may be said that there was some onus on Lionel Desmond to tell you that information, but in your experience ... have you had an experience where patients are suffering from various mental illness and maybe their ability to navigate the details are a little difficult?

A. I'm sorry, can you clarify that question?

Q. I guess, yeah, it was a bad question. I'm trying to rephrase it. So Mr. Desmond is there with his wife and they don't tell you about the Veterans Affairs case manager. But had you known a little bit more about veterans have case managers who coordinate their care, would you have maybe asked them about that?

A. I presume I probably would have, yes.

Q. And why would you have asked them about it?

A. It seems like if that's what these people do then that would be the most streamlined approach to obtaining information.

Q. And I understand that you, on your note again, on this exhibit, page 7, you listed four prescriptions that were down, it said "Current Medications Are"?

A. Mm-hmm.

Q. Now were you able to verify these medications or did they come ... how did you get that information from Lionel Desmond?

A. Mr. Desmond had like a Sobeys bag of his medications with him or a fanny pack, I can't recall, but they were ... he had brought them in with him.

Q. And did he sort of take out these prescriptions?

A. Yeah, we went through them to make a list so that they were on his record.

Q. Did he or Shanna Desmond seem to know exactly what they were for, what they were prescribed for?

A. I think for the most part he understood.

Q. And I'll just review them very quickly and they are medications that I think we've reviewed essentially with every witness.

A. Mm-hmm.

Q. Quetiapine, is it?

A. Yes, that's right.

Q. XR. Your understanding what was that medication for?

A. It could have been a combination of depression and for sleep as well or agitation too.

Q. Okay. And there's ... that's 50 milligrams and it says take daily, is that ...

A. P.O. means by mouth at 19:00 daily.

Q. Okay. And the next prescription is what?

A. Quetiapine XR 25 milligrams by mouth, p.o., t.i.d. means three times a day as needed ... p.r.n.

Q. And what was that prescription for?

A. It could be again for depression, anxiety, or ... depression or sleep or agitation.

Q. Prazosin?

A. Yeah, two milligrams by mouth at night, that's q.h.s.

Q. And what is that normally for?

A. It's often mostly used in PTSD to help control nightmares and sleep.

Q. Zolpidem, I'll get you to pronounce it.

A. Zolpidem, it's a newer version of a medication that many people know of called zopiclone and it's a sleep aid so he would take it, ten milligrams, sublingually is what s.l. means at night at 21:30.

Q. How did the discussion about medications, and you say he pulled them out of a bag of some sort, how did that discussion come about and why?

A. I think, I'm not sure, but often if you're coming to a clinic you bring your medications with you so that we know what you're on so it was more of just harvesting that data so that it would be in his record. He, I think in my note, stated that he was comfortable with where his medication doses were at that time so we discussed changing them but he didn't want to.

Q. Did he express any sort of views he had with respect to taking medication?

A. Not specifically that I'm aware of.

Q. So that day when you meet with him were you left sort of with the impression that he's prescribed these medications and he takes them without any concern or issue?

A. For the most part, yeah. I think I do remember the prazosin and discussing whether or not he wanted to increase the dose at all but at that time he was comfortable with his current dose.

Q. We now know that there's a long history, and you wouldn't be familiar with it, that Lionel Desmond was very resistant to medications at various points, whether it be in

Nova Scotia ERs or whether it be while at the Quebec clinic. Did you get any sense of that? To put it in context, he, in fact, argued with his psychiatrist about not wanting to take certain medications, actively argued. Did you get any sense of that from him when you saw him in October of 2016?

A. Not that I can recall.

Q. Below the prescriptions you noted: "Lately he is finding that he is having more vivid dreams that he remembers." Can you tell us a sense of what he was reporting there?

(14:30)

A. I think it was, if you look at the next line down, that's where we stated the goal of his treatment was to try to avoid this so there may have been a bit of frustration that they were still happening.

Q. But at this point did you know what ... were you able to ascertain what sort of treatments he had for this?

A. Outside of the medications only that he had received therapy.

Q. Below that you noted: "He also reports at times being more agitated and has contemplated drinking but does not want to start this." More agitated, were you able to get a sense of what he meant by that?

A. Yeah, I believe it was just him like kind of being more easily angered about little things here and there but nothing specific that he would have told me and the fact that he had sort of the knowledge that he had contemplated drinking but that he didn't want to was a positive sign.

Q. Did you know the full extent that he, in fact, had previously been diagnosed with alcohol, I'm sure I'll get the actual diagnosis wrong but basically diagnosed as alcohol ... abusing alcohol and it was in remission, did you know that?

A. I can't remember.

Q. Okay.

A. I don't think I did.

Q. Did you get into any discussions about the extent of his previous alcohol consumption?

A. No, I don't believe so.

Q. You note that, below that O.E., what does "O.E." mean?

A. That's shorthand for "on exam".

Q. On exam. What sort of physical observations did you make of Lionel Desmond during meeting with him?

A. So basically he sat kind of, I think, next to me. He was well dressed, he was making good eye contact, his speech was normal, he was thinking clearly and linearly and I wrote that he

had a blunted affect and no suicidal ideations, that's the mental status exam.

Q. So what do you mean by "blunted affect"?

A. In that particular case it referred to just sort of lack of variance in his emotions, they were sort of more monotone.

Q. Was there any sort of consistency in making that type of observations with what he had disclosed to you about depression, PTSD, anxiety or it was just ...

A. It seems fairly congruent with that.

Q. And then you note impressions, what was the ... I guess in terms of your own reporting, is this sort of a category you use typically and say impressions? And what was your impression of the overall visit?

A. Well, I wrote that he likely does have PTSD given everything that he has said to me and that's why he was there for help.

Q. And you noted: "Likely does have PTSD given story."

A. Mm-hmm.

Q. So I noticed you used the word "likely does". So at this point were you able to definitively say this is a military veteran who has been diagnosed with PTSD?

A. I mean, I'm only going on what he's able to tell me at that moment. PTSD is a diagnosis that you typically wouldn't be able to make this in 15 minutes of first meeting someone so without having his previous records I wouldn't want to necessarily medically document the incorrect diagnosis so it's a way of saying this is likely the diagnosis but kind of wait and see what his chart will show us when we receive it.

Q. So we now know that he did have a previous diagnosis of PTSD, chronic intensity PTSD, and as well as major depression and as well as sort of another diagnosis, mixed personality traits or paranoid personality traits. Did you know anything about the diagnosis of or get any sense of the diagnosis of depression or mixed personality traits?

A. Depression yes, but not the mixed personality traits from him, no.

Q. And so you formulate your impression and it's "likely has PTSD given story" and you note plan. Again, is this something typical in your visit, you have a plan going forward?

A. Mm-hmm.

Q. So with Lionel Desmond and wife appearing that day, what was the plan?

A. That we were ... the main plan was to try to access

the notes from Ste. Anne Hospital.

Q. And what was the purpose behind that?

A. Well, I think this man appeared, you know, in no crisis at that time and he was reporting that his medications were under control and, you know, I'm thinking he is sort of entering the public system now but has just gone through an intense program through the military and it would be beneficial to not have to restart everything through the public system if we could pick up from where he left off in the military program.

Q. So as a result of this encounter, did you sort of accept or take on that Dr. Harnish is now going to be the doctor that has to gather the information and coordinate the community care for Lionel Desmond, this veteran, going forward?

A. Not me, specifically, but the clinic I suppose.

Q. So you understand, you sort of formulated the impression that the clinic is now going to have to take sort of responsibility and ownership for Lionel Desmond's care in the community?

A. I mean if he's a patient of that clinic then yes.

Q. And while you formulated this, just to confirm, did you have any idea that there was discussions between the Quebec clinic, the New Brunswick clinic, Veterans Affairs, and the Nova

Scotia OSI clinic that had all been happening?

A. No, it would have been nice to know that at the time but, you know, a goal of obtaining this document from Ste. Anne would have hopefully shed light on that.

Q. And do you think it would have been of some assistance to Lionel Desmond and his wife if you knew someone that you could call and say, Your client, or Veterans Affairs or someone, is here and he's wondering what's up, what's going on with his treatment, would you have done that?

A. Absolutely.

Q. And why would you have done that?

A. Again, just because that would be the natural place to get the information, I suppose.

Q. And then you finish your meeting with Lionel Desmond and what's the last line, Doctor?

A. I don't have it here.

Q. Oh sorry, we'll bring it back up on the screen for you.

A. The last line is: "In event of crisis he's contracted to come back here (meaning the clinic) or to go to the emergency department for help." Or I wrote "ED" for emergency department.

Q. So when you say "in event of crisis has contracted to

come back here and to go to emergency department for help", what do you mean by contracted, is this a sort of medical ...

A. That's sort of medical term that we use that we've had a discussion about, it means contracted to safety. So in moments of crisis when people may not be thinking clearly it means we've discussed, and his wife was present as well, these are the resources you have available to access and we want to help you and that he's agreed that he is aware that they exist and has ... is saying that he's willing to come back and seek that care.

Q. So if ...

A. It's a contact for safety.

Q. So did he and Shanna Desmond seem to appreciate that, look, the ER is present and available in a moment of crisis?

A. This is a standard thing I say for most people but write it when, you know, part of that assessment is them understanding and being aware.

Q. Did Lionel Desmond and his wife seem to appreciate that?

A. I think so.

Q. So after this date, Doctor, what if any sort of action do you take as it relates to you've now gone to Google, you've

now had the veteran come in and say can you help me out, what action do you take?

A. I remember discussing with our front staff to contact the clinic in an effort to obtain the records.

Q. Okay. If we can bring up page 8 of that same exhibit.

THE COURT: We can bring up page 8 and just before you ask the question, did you ever know what Mr. Desmond's wife did?

A. As a profession?

THE COURT: By way of employment or profession?

A. No, I don't think so. I don't think she told me.

THE COURT: Okay. Thank you.

MR. RUSSELL: This note seems to be a little bit of a mystery for some of us.

A. Fair enough.

Q. So it's page 8 of Exhibit 92.

A. Mm-hmm.

Q. Up at the top is says "Lionel Desmond". It's "Guysborough Medical Clinic - Dr. Ali".

A. Mm-hmm.

Q. And then there's a handwritten note ...

A. Right.

Q. ... that says Quebec contact information. "Quebec.

Contact information for chart medical history." There's some phone numbers, do you know what this is?

(14:40)

A. Yeah. So my writing is the phone numbers, the number that starts with N84 is his service number so that's what I probably just grabbed a piece of paper when we were Googling and that's where we obtained the phone numbers and then Lionel and his wife would have given me his service number and then the rest of the writing I believe, at least the "Quebec contact" and the further down is the front staff's handwriting, I believe.

Q. And that note says: "Spoke with Shanna Desmond, October 24, 2016. She indicates it is being taken care of." So did you make that note or no?

A. That's not my writing.

Q. And do you know what it was on October 24th that Shanna said "it's being taken care of"?

A. I don't. I don't even know if I was still in Guysborough at that time.

Q. Okay. So you have no ...

A. I have no recollection of that.

Q. ... of what that is. So, Doctor, it just ... I guess I'll conclude by saying sort of and it's a terrible ... it's an

understatement to say it's a terrible tragedy. But sort of looking back at your involvement and very brief encounter with Lionel Desmond on that particular date and putting as much together as you can, is there anything from your perspective as a locum doctor who appeared in a Guysborough clinic, was presented with a military veteran looking to get you to help him find where to look, is there anything that would have made your professional life a little easier I guess?

A. Oh, I mean, yes. I mean access to information is always going to be, if that's what we were there to do that day, easier access to that would have made it easier.

Q. Okay. Do you have any sort of recommendations in that regard, what it is that could have been perhaps provided to you, whether it's knowledge or ...

A. I'm not sure ... I mean, honestly in the public system compared to the military they are two separate systems so, you know, better integration or collaboration between the two could certainly be beneficial. It's challenging, I think, if you're looking at a national military system going to a provincial system. They're just going to be inherently probably different and there's always an effort to really protect and guard patient information for confidentiality reasons so accessing information

is guarded and it takes time to access that and that's pretty standard. So I wasn't surprised that we weren't going to get his Ste. Anne record that day or probably would take a week or two.

Q. And did it seem to you, and you made a note, that Lionel Desmond was trying to access his own records?

A. No, I don't think that's the intent of my note. I just wrote that ... you mean at the top of ...

Q. Yes.

A. Yeah, that would have been just that he, you know, sometimes I've seen a patient from Ontario, for instance, and they're going back to Ontario and I know the physicians in Ontario won't have access to our information so I provide that, a copy of it for them so that they can take it back to their physician. Whereas ... so I didn't know if he had that with him so ... but I just figured that he didn't.

Q. Okay. And I'll end with this, your overall impression of Lionel Desmond and Shanna Desmond when they came to see you that day and had that meeting, did they appear to really know what was going on and where his treatment was going at that point?

A. I think they had the impression that there was more to

come but specifically what and when they did not know.

MR. RUSSELL: Okay. Thank you, Doctor. Again, I thank you for coming in person, I know it's challenging times.

A. You're quite welcome.

MR. RUSSELL: Your Honour, I don't have any further questions for the witness.

THE COURT: Thank you. Ms. Ward? Ms. Grant?

CROSS-EXAMINATION BY MS. GRANT

(14:45)

MS. GRANT: Hi, Dr. Harnish, my name is Melissa Grant and I'm representing the Government of Canada including various federal entities like Veterans Affairs and the Canadian Armed Forces. Thanks for your time today. Just a couple of questions. I'm wondering if you can explain the concept, it's something that we heard earlier and just from an educational perspective in terms of I don't know if it's a medical ethics term or what, but the concept of the most responsible doctor, is that something that you're familiar with or you can explain to us?

A. Yeah, it often is either the most recently doctor to have attended to a patient or if there's a specific illness, the

main doctor that's championing that illness.

Q. So is it that, you know, if you're seeing a patient are you then the most responsible doctor in that sort of chain?

A. In that moment I suppose, sure, but in the setting of facilitating things you're not always necessarily the most responsible doctor, you're acting under the recommendations of other physicians.

Q. Thank you. And with respect to Ste. Anne, just a point of clarification, you referred to it as a military hospital, it is actually a provincially-run facility in Quebec. So just on that point, and you kind of touched on it there at the end of your testimony, if somebody was coming from Quebec or Ontario or any other province, you would expect that maybe you'd have to make a request for those records?

A. That's correct, absolutely, that's not surprising at all.

Q. And if you had that patient in front of you as you did with Lionel Desmond and his wife and they said like, Look, this is hard pressed to do, can you help us navigate that, you would be willing to ... your office would be willing to assist?

A. Absolutely.

Q. And this may seem like an obvious question to you but

if somebody is presenting at a clinic or presenting at an emergency room, they are receiving health care, is that ... would you agree with that?

A. Yes.

Q. So somebody that is in the public system, the provincial health care system as veterans are like all of us, if I present myself at an ER and I present myself at a clinic, I'm receiving health care from a physician or nurse or whoever it is?

A. Mm-hmm, yes.

Q. Thank you. And in the situation that you had with Mr. Desmond and his wife, it's correct that he ... neither he nor she mentioned that he had a VAC case manager, is that correct?

A. Veterans Affair ...

Q. Veterans Affairs case manager?

A. Yeah. Yes, I did not, I was not aware of that.

Q. So they didn't bring it up and you didn't know?

A. That's correct.

Q. So is it fair to say that the case manager also wouldn't know about your visit?

A. Oh, mostly likely, yeah. I mean it's challenging if you're being discharged, particularly in another province, to

come to a new province and I don't know how the Ste. Anne Hospital would know where to send anything, as well, on their side.

Q. So my friend had said earlier that, you know, sometimes maybe people find it difficult to talk about certain things but you had noted that Mr. Desmond didn't have any difficulty expressing himself linearly, right, is that correct?

A. His thought process was ... yes, it was straightforward.

Q. And his wife was there with him the whole time?

A. That's correct.

Q. Thank you. And so if Mr. Desmond or his wife had said, I have a case manager, I give you consent to speak with her, you would have done that?

A. I believe I would have, yes.

MS. GRANT: Thank you, those are my questions.

THE COURT: Thank you. Mr. Anderson?

MR. ANDERSON: No questions, Your Honour.

THE COURT: Thank you. Mr. Macdonald?

MR. MACDONALD: No questions, Your Honour.

THE COURT: Mr. Rory Rogers?

MR. ROGERS: No questions.

DISCUSSION

THE COURT: Thank you. Ms. Miller?

MS. MILLER: No questions, Your Honour.

THE COURT: Okay. Mr. Adam Rodgers?

MR. RODGERS: No questions, Your Honour.

THE COURT: Thank you. Ms. MacGregor?

MS. MACGREGOR: No questions, Your Honour.

THE COURT: Thank you. Any follow-up?

MR. RUSSELL: Nothing on re-direct, Your Honour.

THE COURT: Dr. Harnish, I don't have any questions for you. I asked you a question a little while ago so what I'm going to do because you're here and because you dealt with Cpl. Desmond and because there were a lot of things that were going on that you weren't aware of at the time, particularly as it related to Cpl. Desmond and his relationship to the military, in particular, Veterans Affairs Canada and the fact he'd been in the OSI clinic. It's actually a residential treatment clinic, occupational stress injury, in Ste. Anne's in Montreal. He'd been there for a period of time so there's just a couple things I wanted to tell you. It's just, in part, for informational purposes for you.

(14:50)

DR. HARNISH: Thank you.

DISCUSSION

THE COURT: And when I asked you if you knew what Lionel Desmond's wife did for a living, she was a registered nurse and worked at St. Martha's so to the extent that she was engaged in conversations with you about her husband, she would have at least some of that background ...

DR. HARNISH: Yes.

THE COURT: ... that any registered nurse would bring, number one.

Number two, when you looked at trying to assist in tracking down his records and there was a note on Exhibit 92, page 8 that said: "Spoke to Shanna Desmond October 24, 2016, she indicates it is being taken care of." We know that on October 24th, that's the day that he attended at St. Martha's Hospital and he went through the emergency department, they did a very extensive assessment of him that day and he, in fact, was seen by Dr. Slayter that day who then provided some reports and was going to do some follow-up himself.

So the fact that she then turned her attention back to your clinic to let your clinic know that that was being looked after, I would assume that her view was that the follow-up with regard to the medical records would come through either St. Martha's or through the efforts of Dr. Slayter.

DR. HARNISH: Sure.

THE COURT: So that was done as well so just to kind of complete some of the circle for you.

And then lastly, in the event that you encounter a situation again, when Cpl. Desmond was released from Ste. Anne's Hospital, prior to his release there was a conference call with the individuals at Ste. Anne's together with, among others, his case manager in Veterans Affairs Canada. Okay? So that's the case manager we're talking about.

DR. HARNISH: Mm-hmm.

THE COURT: And one of the things that eventually would go to a case manager would be the discharge summary. So when you're looking for medical reports, for instance, trying to figure out what the veteran's situation might be and he references a case manager and he's been in an OSI clinic, any discharge reports would wind up in the hands, should wind up in the hands of a case manager. So if you had contacted the case manager, depends on the ... that would have been a November date, I think the case manager would have had the discharge summary, that would have been presumably available to you through the case manager at that point in time. So you're right, that would be a good route to go if you're dealing with a

veteran ...

DR. HARNISH: Absolutely.

THE COURT: ... in a circumstance like that again.

Ste. Anne's, in this case Cpl. Desmond was released, he was referred to that clinic by the OSI, the operational stress injury clinic in New Brunswick, so they would have been engaged in the conversation prior to his discharge. They eventually would have received a copy of the discharge summary as well.

DR. HARNISH: Mm-hmm.

THE COURT: Or even if you look at plugging into the OSI in New Brunswick as opposed to the case manager, you would have had access, you would have found somebody who should have been able to give you some information, with consent, about what his situation was in Ste. Anne's.

So just in the event you find yourself in that situation again, there's a bit of a roadmap for you.

DR. HARNISH: Thank you.

THE COURT: So we appreciate your time today, the information that you've given us, it's all important in terms of trying to sort out what all the situation was and the circumstances were that led to the events that bring us here today and might lead us to some recommendations that will be

useful in the future.

Thank you for your time. Appreciate it.

DR. HARNISH: Thank you, Your Honour.

THE COURT: Thank you.

DR. HARNISH: And if I can just also say my sympathies both to the Desmond and Borden family.

THE COURT: I'm sure that's appreciated, thank you. Thank you. If you want to slip your mask back on and we'll excuse you, that's great, thank you for your time.

DR. HARNISH: Thank you.

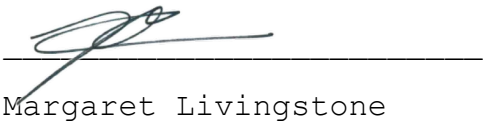
WITNESS WITHDREW **(14:54 HRS)**

THE COURT: I think that's it for the day then, Counsel. I know our days have been a little shorter but I know our days are going to get longer. Enjoy it while you can. Thank you. Tomorrow morning 9:30, thank you.

COURT CLOSED **(14:55 HRS)**

CERTIFICATE OF COURT TRANSCRIBER

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



Margaret Livingstone

(Registration No. 2006-16)

Verbatim Inc.

DARTMOUTH, NOVA SCOTIA

April 2, 2021