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: November 1, 2021

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

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

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

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

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

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

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

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

INDEX

EXHIBIT LIST

EXHIBIT LIST

November 1, 2021

COURT OPENED (09:38 HRS)

THE COURT: Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: This morning we're going to hear some evidence from Dr. Theriault. Good morning, Dr. Theriault.

DR. THERIAULT: Good morning, Your Honour.

THE COURT: Thank you for attending today. There are just, I think, a couple of matters that I need to deal with.

During one of the last sessions when we heard, I think, evidence from Ms. Borden, there was some discussions with her in relation to some text messages that she thought she might still have available on her phone. Have those been distributed to counsel?

THE CLERK: Yes, they have, Your Honour.

THE COURT: And I think counsel have a copy of those. So there is a series of text messages that are going to be marked as exhibits; the Inquiry document number "INQ" followed by a number of zeros.

EXHIBIT P-000316 - TEXT MESSAGE 1 - NOVEMBER 28, 2015

108 which is going to be Exhibit P-000316. That's a text

message, November 28th, 2015, between Shanna and Shonda.

EXHIBIT P-000317 - TEXT MESSAGE 2 - DECEMBER 08, 2015

The next document would be Inquiry document 109. It'll marked as Exhibit P-000317. That's a text message, December 08 between Shanna and Shonda.

EXHIBIT P-000318 - TEXT MESSAGE 3 - JUNE 3, 2016

Next document will be Inquiry document 110. It will be marked as Exhibit P-000318. That's a text message, June 3rd, 2016, between Lionel and Shonda.

EXHIBIT P-000319 - TEXT MESSAGE 4 - JUNE 3, 2016

The next document will be Exhibit P-000319. That's Inquiry document 111. It is a June 3rd, 2016, text message between Lionel and Shonda.

EXHIBIT P-000320 - TEXT MESSAGE 5 BETWEEN LIONEL AND SHONDA

Next document would be Inquiry document 112. It'll be marked as Exhibit P-000320. It's a text message between Lionel and Shonda.

EXHIBIT P-000321 - TEXT MESSAGE 6 - NOVEMBER 26-27, 2015

Next is Inquiry document 113, marked as Exhibit P-000321. It's a text message, November 26-27, 2015, between, is it Lionel or Leon?

THE CLERK: That's what it showed "Leon".

THE COURT: It shows as "Leon" and Shonda. I think that is Lionel.

EXHIBIT P-000322 - TEXT MESSAGE 7 BETWEEN LEON AND SHONDA

The next document is Inquiry document 114 marked as Exhibit P-000322, also a text message between what shows as Leon and Shonda.

EXHIBIT P-000323 - TEXT MESSAGE 8 - MAY 27, 2015

The next is Inquiry document 115 marked as Exhibit P-000323; text message May 27, 2015, between Leon and Shonda.

So those are the additional matters.

EXHIBIT P-000326 - RESEARCH ON THE NOVA SCOTIA MEN'S HELPLINE

We have, as well, Inquiry document which will be 116. It's going to marked as Exhibit P-000326. That is the research on the Nova Scotia Men's Helpline that we had inquired about and that was forwarded to us.

EXHIBIT P-000327 - NOVA SCOTIA MEN'S HELPLINE EVALUATION REPORT

And, as well, Inquiry document 117, which will be marked as Exhibit P-000327, which was the Nova Scotia Men's Helpline Evaluation Report which we had made a request for that as well.

So did I capture all of them?

THE CLERK: Yes.

THE COURT: All right, thank you. So that will bring us

up-to-date with regard to some of the outstanding documents that we had looked for and had been promised.

The research with regard to the Men's Helpline and the evaluation, I think that that was evidence or material that was referenced at least by Ms. Nancy MacDonald and possibly by Ms. Stephanie MacInnis-Langley as well. All right, thank you.

EXHIBIT P-000328 - REPORT AND *CV* - DR. P. S. THERIAULT

So as I said this morning, I think we have Dr. Theriault, we have some exhibits as well. Dr. Theriault provided us with a report and a *CV*. I think those documents, combined, have been marked as one exhibit. Is that Exhibit 325?

THE CLERK: 328.

THE COURT: Oh, I'm sorry, 328?

THE CLERK: Yes.

THE COURT: All right, thank you.

And just for the benefit of those that are new to the room, when the Inquiry moved from Guysborough to Port Hawkesbury following the particular wave of COVID-19, this courtroom was set up in such a way that it would be compliant with the Public Health directives. The requirements that were in place generally when this court reopened are still in place. That would require witnesses who enter the courtroom to always be

wearing a mask, and when they move about in the courtroom, to always wear a mask.

In the case of Dr. Theriault, I would ask you to come to the witness stand; ask you to place your mask back on. And when you come to the witness stand, you would have the option to remove your mask if you're comfortable doing that. If you choose to continue to wear your mask, that's entirely up to you as well.

We have all of the Public Health protocols in place and it's my belief that double vaccination exists in this room, so we have that added degree of comfort as well, if I can put it that way.

All right. Dr. Theriault, if you could come forward then, please? Actually, you'll probably have to go around the back there to get you over to that seat.

MR. RUSSELL: Good morning, Your Honour. If I just may grab a Kleenex.

THE COURT: Absolutely.

DR. P. SCOTT THERIAULT, affirmed, testified:

THE COURT: I know that there's a fresh bottle of water there in front of you, Dr. Theriault, so feel free as you might require it, and if you run out, we have more for you as well.

DR. THERIAULT: Thanks.

THE COURT: I think Mr. Russell will have some questions for you this morning. Thank you.

DIRECT EXAMINATION BY MR. RUSSELL

MR. RUSSELL: Thank you, Your Honour. Good morning, Dr. Theriault.

A. Good morning.

Q. Thanks for attending this morning.

A. Thanks for asking me.

Q. Just, I guess, where we're going to start, Doctor, is a little bit about you as a professional and we'll review some of your qualifications just so we can orientate the Court to your area of expertise and your history of employment and qualifications.

So I wonder if we could bring up Dr. Theriault's *CV*?

THE COURT: Doctor, all of the information that we bring

up on the monitor is also available to you in the binder to your left on that table.

A. Oh, thank you.

THE COURT: In the event that you're more comfortable looking at a hard copy, feel free. We can always move that table over a little bit if you like and you can flip the binder open to dig it out.

A. Thank you.

THE COURT: All right. Your choice. You just have to let us know what you want to do. And I think there's a copy of your report. Actually ...

A. In the front.

THE COURT: ... the document that's in front of you, that's for you. That's a fresh copy of the Exhibit 328 which is your report, and I think your *CV* is attached to the latter portion of that document as well.

THE CLERK: Page 64.

THE COURT: Page?

THE CLERK: 64.

THE COURT: Beginning at page 64. I think that's where your *CV* can be found.

A. Found it, thank you.

THE COURT: All right.

A. Yeah.

Q. Thank you.

MR. RUSSELL: So, Doctor, if, at any point, it's unclear which passage or portion I'm referencing, please feel free to just say, I'm trying to orientate myself. We'll take a moment to make sure you see what I'm referring to so we're literally on the same page.

A. Okay, thank you.

Q. So, Doctor, I guess, could you state your full name for the Court, please?

A. My full name is Dr. Peter Scott Theriault. My last name is spelled T-H-E-R-I-A-U-L-T.

Q. Doctor, what is your current occupation?

A. I am a forensic psychiatrist employed at the East Coast Forensic Psychiatric Hospital by Nova Scotia Health, and I am an Associate Professor with the Department of Psychiatry at Dalhousie University.

(09:50)

Q. And, Doctor, before we get into your *CV* itself, I wonder if you could tell the Court, generally, what is a forensic psychiatrist and how is a forensic psychiatrist

different than a general psychiatrist?

A. Well, generally, the definition of a forensic psychiatrist is a psychiatrist whose expertise is in the application of psychiatric knowledge to legal issues. So it differs from a general psychiatrist in that a general psychiatrist's knowledge would span the width and breadth of psychiatry generally, but a forensic psychiatrist uses that knowledge to apply to particular medical/legal issues.

Q. And, Doctor, so a forensic psychiatrist, is it fair to say, is a subspecialty, I guess, of psychiatry?

A. Well, the Royal College of Canada is the body that designates subspecialties in Canada. So, for many years, forensic psychiatry was not a recognized subspecialty, but in 2001, the Royal College declared four subspecialties in psychiatry; so they were forensic psychiatry, geriatric psychiatry, and child and adolescent psychiatry. Sorry, three subspecialties. So it's been a recognized subspecialty since that time, which means that in order to be a forensic psychiatrist, and recognized as such, you have to have training through a residency program and then pass a qualifying exam.

Q. And that's what I was going to ask you next is sort of, I didn't imagine that a psychiatrist one day just decides,

I'm going to be a forensic psychiatrist tomorrow, and away you go. If you could tell us just generally, what sort of additional skills or education does a psychiatrist require to be designated and classified as a forensic psychiatrist?

A. Well, in general, a forensic psychiatrist would first complete their general psychiatry residency. So a residency in psychiatry is normally five years in length, so you would complete medical school, and then you have a five-year residency program in general psychiatry, and then that makes you a general psychiatrist if you pass your examinations before the Royal College.

And then, to become a forensic psychiatrist, you would normally do what we would call a "fellowship" or an extended residency in forensic psychiatry. So that would normally extend the training for another year or two, depending on which program you may go to to do that. And, during that period of time, you would be exposed to a number of medical/legal issues in learning about forensic psychiatry. So, in broad terms, that could include criminal forensic psychiatry; so issues related to, for example, criminal responsibility and fitness to stand trial which is the common work that we do at the East Coast Forensic Psychiatric Hospital. It could include civil matters; so tort

law, that sort of thing. It could include the regulation of different professions; so forensic psychiatrists are often involved in doing assessments for different regulated professions. So you would get experience in all of those areas.

Another area is issues related to sexual offending, for example; so dealing with that population of offender.

So, during those two years, you would get exposure to those different areas and, hopefully, depending on your program, an opportunity to testify in court and learn how the court system works and what to expect when testifying, and how to do so efficiently.

Q. How many forensic psychiatrists do we have in Nova Scotia currently?

A. There are five of us, but we've just hired a new one, so we'll have six soon.

Q. And, Doctor, have many years have you practiced in the area of forensic psychiatry?

A. This is my 30th year as a psychiatrist and this would be my 23rd year as a forensic psychiatrist. I did practice general psychiatry for a number of years before I did my subspecialty training.

Q. So over 20 years of forensic psychiatry. Would you be

the most senior forensic psychiatrist in the Province?

A. To the best of my knowledge, yes; that's still in practice anyway.

Q. Okay. So, Doctor, if we could turn a little bit to your *curriculum vitae*. So, I guess, starting with your degrees, we see that, at the very of the top, we see that you received your Doctor of Medicine in 1986.

A. That's correct.

Q. I'm interested in 2008/2009, you note that there was an international diploma that you had received. What was that?

A. Well, I've always been interested in mental health law and I have always been interested in human rights, and the WHO - the World Health Organization - has, for a number of years now, funded a diploma program in Mental Health Law and Human Rights, and I was part of the inaugural program for that diploma. So I had the opportunity to go to India, where the program was held, for two years to undertake that program. So that's what that is. So that was, and remains, an area of interest of mine.

Q. Okay. In terms of, just below that, we have post-graduate training. In particular, I guess, we see "1997/1998 - Fellow in Correctional and Forensic Psychiatry - Queen's University". Is that sort of the start of your, I guess,

specialized training on the road to becoming a forensic psychiatrist?

A. Yes. Most fellowship programs run on the academic year which usually runs from July to the end of June of the following year, so that's why it's listed as 1997/'98. I was a student at Queen's University for that year and did rotations through Kingston Penitentiary, which was still open at that point in time, and my mentor was Dr. Stephen Hucker who was a senior forensic psychiatrist in Ontario.

Q. And I understand Dr. Hucker may still practice?

A. As far as I know, Stephen still practices.

Q. Okay.

A. Yes.

Q. In terms of your licenses and credentials, you touched on this very briefly. I'm mostly interested in, well, a few things, but 2011 to present, it says, "Founder, Forensic Psychiatry, Royal College of Physicians and Surgeons of Canada". What is that "Founder - Forensic Psychiatry" designation as of 2011?

A. Well, when forensic psychiatry was designated as a subspecialty, part of the work that needed to be done through the Royal College was, in order to set up the process of the

subspecialty, you have to develop a curriculum; you have to develop sort of the set expectations for students that would study forensic psychiatry; you have to put the curriculum together; you have to set out the expected competencies that they would gain over the course of the year that they're in training. And the Royal College has a process where they asked a group of forensic psychiatrists from each region of the country to be on the initial group that created that curriculum. So I was asked, as the regional representative for Atlantic Canada, to join that group and, in recognition of that, I was designated a founder of forensic psychiatry in Canada.

Q. Okay. A pretty significant accomplishment?

A. Well, we did a lot of work, yes, to get it up and running.

Q. In terms of licenses you hold to practice the area that you practice, your licenses and credentials, you note that you hold a license in New Brunswick, Nova Scotia, and a consultation specialist in PEI. Is that correct?

A. Yes. So I have a full license in New Brunswick because I periodically go to New Brunswick to do medical/legal cases, primarily in criminal law in the last number of years, and I hold a consultant license in PEI essentially for the same

purpose; to go over and see consults at the request of other people.

Q. So in addition to your, I guess, primary role, if that's fair to say, you had a number of faculty appointments - and they're recent - with Dalhousie University. You indicated that you ... in your *CV*, you indicated in '91, you were a lecturer until 2004; then in 2004-2006, assistant professor; 2006 to present, associate professor.

I'm wondering if you could indicate, I guess, for the Court a little bit about your role as associate professor at Dalhousie University, Department of Psychiatry and, generally, I guess, what sort of courses or research you're involved in with the university.

A. Well, the university appointment process is set out in the By-laws of the Faculty of Medicine. So the ranks are generally lecturer, assistant professor, associate professor, and then full professor. You move from one rank to another over the course of years based on applying for an increase in your rank, and that depends largely on ... the Faculty of Medicine will look at a number of things. They look at your clinical work, they will look at your educational activities, and they look at your research activities. And so I've moved from a

lecturer to associate professor. The next rank would be a full professor, which I may or may not get to at some point in time, I suppose.

(10:00)

Because I'm primarily a clinician and not a researcher, in general, within the Faculty of Medicine, full professors tend to be sort of more research heavy. They have higher loads of research time than I do so my ... I've been quite happy, frankly, to be an associate professor for many years. That's my ... reaching that rank would dependent ... depends on my clinical duties, my teaching activities with students that we have at the hospital and, for me, because I have a fair amount of administrative responsibilities my administrative role as well.

Q. Okay. While we're not undertaking a typical **Mohan**, I guess, *voir dire* about your qualifications and asking the Court to qualify you as an expert in your area, that's certainly that's a given for the purposes of the Inquiry, I'd like to review a little bit of your work experience and sort of generally what you did in those settings to sort of give everyone sort of an overall flavour or sense of your experience and then ultimately we'll tie that experience in to why you're

here today.

But if I could start, I guess, page 2 of your CV. 1997/98 it says Correctional Services Canada Regional Treatment Centre. What was your role there as a forensic psychiatrist?

A. Well, that was the year that I was in training, so over the course of that year I was a psychiatrist at the Regional Treatment Centre. So Correctional Services of Canada has a series of what are referred to as RTCs, regional treatment centres, across Canada that are specifically for psychiatric issues. So at the time I trained this one was in Kingston Penitentiary which, of course, has since closed, but. So over the course of the year my role there would have been to do routine psychiatric assessments and treatments of individuals within that CSC environment.

Q. And was that sort of a busy environment, Kingston Penitentiary?

A. It was very busy, yes.

Q. Okay.

A. Yes. As we know, the rates of mental disorder in correctional populations is quite high so we had lots of activity and work to do while I was there.

Q. Okay. And next it says between 1998 and 2011, so for

a period of 14 years you acted as Clinical Director - East Coast Forensic Hospital. So for those 14 years what was your role as the Clinical Director of the East Coast Forensic Hospital?

A. Well, part of that begins with the history of the forensic hospital. So when I finished my residency ... my fellowship training in '98 and came back to Halifax we were in the process of developing two things. One was a new model of care for forensic psychiatry at the hospital and the other was a new facility. So we ended up moving from the Nova Scotia Hospital to the East Coast Forensic Psychiatric Hospital which is in Dartmouth for anyone that's been there in 2001.

And so when I came back from my fellowship training I became the Clinical Director and was in charge of developing and implementing that new clinical program for the hospital and I was part of the team that oversaw the construction and movement of all of our staff and patients to the new facility in 2001 when it opened and then I remained Clinical Director thereafter until 2012, is that right?

Q. And during that period of time when you were Clinical Director, did you still operate in the capacity of a forensic psychiatrist in that you had done various assessments and ...

A. Yeah, my work at that time would have been ...

essentially I'd always think of it as two-thirds/one-third. So two-thirds of my times would largely be spent doing clinical activities, so seeing cases, doing assessments, managing patients that had been found unfit or not criminally responsible. The other third was largely given over to administrative duties, so managing sort of the other staff at the hospital, managing the general sort of service delivery models, those sorts of things.

Q. And then we see in addition there's some overlap here, 2003 to 2006 it's with the Capital District Health Authority which we all know has I guess, since disbanded, it's an old title. From that period of time for three years you were the acting Chief of Psychiatry. What was your role there as acting Chief of Psychiatry?

A. Well, what had happened at that point was that the head of the Department of Psychiatry at Dalhousie who is also by definition the Chief of Psychiatry for the Health Authority, had stepped down and so we had an interim head and rather than the interim head acting as both the interim chief and the interim head I became the acting chief. So that meant that I essentially took over the responsibilities for the all clinical service delivery for all of the Nova Scotia Health Authority-

related mental health services that's provided by psychiatry.

Q. Okay. And 2007 to 2011 for a period of five years you are listed as Clinical Director of the Capital District Health Authority. So how was Clinical Director different than Acting Chief of Psychiatry under the old model which was Capital District Health Authority?

A. Well, in 2007 we had a new head so the new head, like I said became the Chief of Psychiatry, but as Chief Psychiatry the new head then designated two positions. So one was for forensic and specialty services for which I became Clinical Director and one was for general services for which, if I remember correctly Dr. Ian Slayter, at the time, became the director.

Q. And sort of what was your role there as Clinical Director?

A. Well, it was very similar to the Acting Chief. So my responsibilities would be the oversight of the forensic service as it always had been the case but also oversight over our specialty mental health services. So within the Central Zone, in particular, we have a number of specialty mental services that are related to the university Department of Psychiatry, so things like mood disorders, early psychosis program, eating

disorders, those sorts of things, so I would have had oversight over that part as well.

Q. I guess before turning to your current roles within the Nova Scotia Health, I guess I'm curious as to how you found the time for so many multiple roles in so many areas in so many departments?

A. That's a good question. I don't know, I mean I've always thought of myself as being fairly efficient in what I do and I've always been ... on the administrative side I've ... essentially, I like to think of it anyway, that I've always been a person that I don't tend to talk if I don't need to. So before I say something I usually think it through and so I'm the sort of person in a meeting where I might not say much but when I do people usually say, Oh, okay, we'll listen to Dr. Theriault. So that creates a certain amount of efficiencies in my day I find, so I've just managed to juggle that over the years.

Q. Okay, but hopefully today we'll get you to talk quite a bit because there's some heavy topics that we're looking to discuss.

So this is highly relevant to your role here today from our perspective. So 2011 to the present, so that's a period of ten

years, and you currently are the Clinical Director - Nova Scotia Health Authority - Mental Health and Addictions Program - Department of Psychiatry. Correct me if I'm wrong there, but is that your current official title as it relates to Nova Scotia Health?

A. Yes, that's my current title. So that's when ... after 2011 we shuffled the cards again so to speak. So organizations always go through restructuring so we essentially restructured the department again so that I became once again the overall Clinical Director for all the mental health programs within the Health Authority.

And, of course, once we became Nova Scotia Health Authority instead of Capital Health then, as you are probably aware, we now exist in four zones or four Health zones. So one of those is Central Zone, which, from a mental health perspective is the largest of the four both in terms of population and in terms of sort of professionals that work in that area. So as Clinical Director I have oversight over all the mental health and addictions programs in Central Zone.

And I do that through a co-leadership model with ... my director is Ms. Rachel Boehm who's currently the Director for Mental Health and Addiction Services for Central Zone, and then

Rachel would report to Sam Hodder who would now be ... because we've tried to develop the program in Nova Scotia where we become more of a provincial program and less of sort of a we do this in this zone and we do that in the other zones, so ...

Q. Okay.

A. ... sort of training to create a more homogenous kind of model. So, in effect, we all report up but for clinical expectations we report up to Sam Hodder who's the Director for Mental Health and Addictions for the province along with Dr. Andrew Harris who is a colleague of mine and a psychiatrist that's the medical director for Mental Health and Addictions.

Q. So you indicated that you see sort of a shift in which rather than the independent four zones, I take it, sort of doing their own things now there seems to be a desire to keep things consistent throughout the province under one model?

(10:10)

A. Yes. Well, of course, remember years ago we had no less than nine districts, so that was even more problematic because each district had its own policies, its own procedures, its own resource-base to work with. Now that we've moved to sort of the model that we have now, although we have four zones we very much want to create a model that creates a province-wide

structure where ... and I always think of this from the patient perspective so that any patient can expect to get the same service regardless of where they reside in the province.

So, I mean, that's a bit of a challenge because of course we still have resource issues in various areas and there's a rural/urban sort of divide that creates challenges both logistically in terms of practice, but that's the model that we're trying to develop currently.

Q. And do you see the benefits of that?

A. Oh very much so. I think that it leads to ... again, from a patient perspective it leads to better patient care because what we're trying to do is to create a model where we would have guidelines for different disorders, for example. So there are a number of guidelines that are promulgated now that relate to practice, so how do you treat major depression, for example.

So we're trying develop a system where those sort of models would be distributed around the province and then ... so you could expect that if I develop major depression and I show up in hospital in Antigonish the service I'll get would be the same as the service I would get in Halifax or it'll be the same service that I might get if I went to Yarmouth, right, in terms of the

general application of those guidelines.

Q. We've heard quite a bit, and this is taking a little detour, but we've heard quite a bit during the Inquiry about doctors using different sort of databases. We heard a bit about MEDITECH and other programs that they use to access information and the importance of sort of merging everything in terms of record sharing and keeping under sort of one consistent program.

A. Yes.

Q. Now would you be involved in something like that?

A. I'm not directly involved in it. We do have ... and of course names change over time, but there has been a process going on for some time called OPOR, it was called One Patient One Record ...

Q. Yes.

A. ... but now it's called One Patient One Experience. I'm not sure what the difference is, frankly, but it's a good new name, I guess, so ...

But the idea behind that would be that at some point as we move to electronic medical records, that I would be able to go to any site in the province, log in and then that patient's records if I'm looking up a patient, would be available for me to review without having to sort of figure out how to get

another system online or contact somebody so that they have to print off the records and fax them to me or courier them to me, those sorts of things. So that process has been ongoing for a number of years but I think that, hopefully, we're starting to see some progress in developing that model, it's ...

Q. So you've seen scenarios where you've had to get records faxed to you and records couriered to you from another sort of district or another hospital?

A. Well, certainly, yes. I mean, so, for example, in my forensic work we would routinely get ... we routinely get patients from all over the province. So unless they're from Central Zone in which case I can look them up in what's called One Content which is our database record for Central Zone, I would have to then call the other hospitals, say, South Shore Regional and say, Could you send me all the mental outpatient records on Johnny, right. And they will say, Well, how many years do you want to go back. And so then I have to figure out how many years I want to go back and get the records and then they will fax them to me or courier them to me.

Q. Okay. So do you see ... sorry, Your Honour.

THE COURT: Sorry. Dr. Theriault, the One Patient One Experience record system, is it the same as the One Patient One

Record with just a different name or is it a differently designed system?

A. I don't really know all the details. It's roughly the same system. I think that there's been some ... obviously all these things have delays. I mean, the original timeframe for the OPOR was ten years which seems like an awful long time to get something done frankly, but by the time you get it done you'd have to get a new system in place. But with this new system I think they're trying to accelerate the timeline. So the last that I heard is that they're hoping to have a running model up within two years which would be a vast improvement over what we've had.

THE COURT: So two years, would that be like 2023 or two years from ...

A. Well, I think it's ... the last I'd heard was two years from ... so 2023/2024, something like that.

THE COURT: All right. Sorry, Mr. Russell. Thank you, Doctor.

MR. RUSSELL: So, Dr. Theriault, I guess as a practicing psychiatrist and, in particular, a practicing forensic psychiatrist, what is I guess the advantage of whether it's a psychiatrist in an ER setting or a psychiatrist in a clinic

within the hospital under the Health Authority be able to sort of go online perhaps, click in a file and then see a patient's entire experience. Is there an advantage for a psychiatrist to be able to have that easy access to that information?

A. Well, the advantage is that it allows you to be able to develop an understanding of the patient that you can't have this through interview with the patient alone. So I mean that's an advantage. Of course a system is only as good as ... the information is only as good as the system. So one of the issues that we've had with our system is that, honestly, it can be sometimes hard to find information. It gets buried in different places and messed up in files and that sort of thing. So it can be time-consuming to go through those sorts of files as well.

So there's an advantage but there's also a need to be sort of ... either to be able to efficiently gather that information or be cognizant of how much time you could spend going down the rabbit hole, so to speak, of looking up patient information which can take a lot of time.

Q. So we've heard a little bit about various witnesses along the chain that was Lionel Desmond and professionals that interacted with him. We heard a little bit about a worry that they were sharing too much information as opposed to you're

better off just sharing a synopsis of the file as opposed to the entire file, which obviously can be missing pieces depending on who's doing the synopsis. From the psychiatrist's perspective at the very sort of end of the day, whether you're the psychiatrist in an ER room or you're the psychiatrist doing a final assessment or coming up with a treatment plan or an ultimate assessment, is there such a thing as having too much information?

A. Well, that's a good question. I think that part of it does depend on contact. So, for example, for me if I'm doing a forensic assessment on a serious case, say a murder case which I do from time to time, I would normally want to see all the information available to me but, in part, that's because I've got 30 days generally on a court-ordered assessment to review that material, see the individual, gather information and sort of draw my opinions out for the court. Contextually that's a bit different than an emergency room situation where you're usually under considerable time pressures because if you're, for example, in a our Central Zone it wouldn't be unusual for us to have three or four patients in the emergency room waiting to be seen so ... So the information is useful but it also has to be meaningful.

So sometimes you ... to go through all that information would create a situation that it would be difficult to sort of do the assessment in a reasonably expedient kind of way. So there's a balance to be struck I guess is what I'm saying.

Q. Would you prefer to be able to have access to that information? As the psychiatrist in that situation, you be the one to make the decision what is sort of relevant and not relevant or would you prefer to have just limited access of and not know if some details may be missing?

A. Well, I would prefer to have all the information but ideally I'd like the information collated in kind of a way so that I could sort of pull out the important things. So, for example, in our system it wouldn't be unusual for example, to have somebody have all sorts of written notes over time, although we're moving away from that and getting into electronic notes which, frankly, are a lot easier to read, that's one.

And then you would have, for a general outpatient assessment, we would have a letter that goes out to the GP that sort of summarizes much of that detail, so. So sometimes it's just more ... in a time-sensitive situation it's just easier to look at that than sort of read through the entire sort of ...

Q. I guess, if you use an example and bring it directly

to this is, you've sort of had the luxury of reviewing all of the records, and I'll ask you a little bit about that in a bit, but as it relates to Lionel Desmond going back to private practitioners, health authority records, CAF records of professional, psychiatry reports, St. Martha's, Ste. Anne's, I guess putting yourself in the shoes of, I guess, Dr. Rahman who is the ER physician that sees him on January 1st/January 2nd, would you have liked to have had ... knowing what you know now that was contained within the CAF records and the Ste. Anne's Quebec facility, is that some information that you think would have been valuable to have?

(10:20)

A. In the context of an emergency room assessment?

Q. Yes.

A. Well, it would be useful information to have but, again, you would have to ... you have to sort of set it in the context of what the environment was like on the day that that assessment took place, right. What were the other demands on time in the emergency department, those sorts of things.

So it would be useful to have some of the highlighted information certainly to make sure that any decisions that you made where consistent with that information, but to have that

whole record ... you said I've had the luxury of reviewing it, I don't know if I'd call it luxury, frankly, but ...

Q. Oh yes.

A. Yeah, you know, it's very time-consuming to go through all that information so ...

Q. Okay. But would you say that there are some benefits of having select portions of that record in front of you if you were in the ER position or a psychiatrist?

A. Yeah, I would think so.

Q. So just sort of moving to briefly your role as Deputy Head with Dalhousie University, Department of Psychiatry, so what is your role there?

A. Well, just to update the court, I'm no longer deputy. We have a new head that ... this is now the fifth head I've served I think over the course of my career. We have a new head of the Department of Psychiatry that started in September. So as part of the new head's role he's chosen a new deputy head of the Department so I'm no longer deputy head of the Department.

Q. Okay.

A. But over the period of time that I was, the deputy head's role is to ... it's largely an administrative role, it's largely ... it's you're involved in a number of core committees

at the departmental level and you're the person that takes over the duties of the head if the head is unable to do so over a period of time.

Q. What sort of courses do you teach at Dal?

A. It varies from year to year, but I've taught courses at the undergraduate level, so lectures in mental health. We have a particular program that I like at the medical school called Pro Comp, which is Professional Competencies, so it's a program really geared towards helping students understand what the broader societal and sort of health issues are in medicine and sort of what their professional responsibilities are as medical professionals, that sort of thing, so I like that program.

I've taught at the residents level so we have residents on a regular basis. And because I'm a forensic psychiatrist I taught forensic psychiatry to residents and I've had several Fellows over the years.

Q. In terms of Scientific and Conference Abstracts, there's a number of them noted that you were involved in, but the general theme, I think it seems to be changing trends in forensic psychiatry in Canada. Are there any sort of changing trends over the last few years that you can point to as it

relates to forensic psychiatry? Can you give us a general sense?

A. Well, forensic psychiatry is a discipline where, from my perspective of 20 years, it goes between different poles. So one of the core issues in forensic psychiatry is what we generally call risk versus recovery. So in forensic psychiatry you're always concerned about what a person's potential risk to the public is, especially if you're dealing, for example, with NCR accused.

So forensic psychiatry tends to go through waves where we lean in heavily on the risk part and don't give a lot of thought to the recovery part; that is, the returning the person to a place where they could become a productive citizen of their communities again, and then we veer the other way and over-focus on recovery and ignore the risk issues so ...

I mean part of the program that we had developed early on when we went to the East Coast Forensic Psychiatrist Hospital was we had made a deliberate decision to focus more on recovery issues so we developed a recovery model and we practised that for many years. But depending on the population of patients that we have, the staff that we have, those models tend to go back and forth, so it's a constant sort of work to sort of try

to find a balanced perspective between the two, so that's much of the sort of work that happens in forensics.

Q. So would you say sort of at the core duties of a forensic psychiatrist is an assessment and evaluation of risk and an assessment and evaluation of how recovery is possible in any given client?

A. Well, I think of it in the general work that I do as a two-step process. So the first step is generally, of course, we do the court-ordered assessments and then we'll give an opinion to the court as to whether we think whether an accused is fit to stand trial, whether they meet criteria, say, for a section 16 offence, that's the NCR defence in Canada.

And generally at that time I'm not really concerned about either issues of risk or recovery because I'm focused on sort of clarifying my opinion to the court so that they can make a reasoned choice about what happens next.

But if a person is found not criminally responsible then my focus becomes both of those things. So it's trying to understand what the risk factors are for that individual, how we can mitigate those risk factors, and in the context of their broader mental illness, which for most NCR clients is a psychotic disorder of some sort, usually it's schizophrenia/bi-

polar disorder. How we can best manage that disorder in such a way that they can eventually return to the community and their risk is appropriately managed, that's the work of a forensic psychiatrist.

Q. So I'm somewhat curious and it ties in to your current series of presentations and role with the Health Authority, is your experience with forensic psychiatry reviewing the connection or nexus that's mental disorder and sort of criminal activity or violent-related activity and your presentations which were if we scroll down on the *CV* to the next page ... if we move down. There was a number of presentations that you did that ... it said Proposed Improvements in Mental Health Care in Nova Scotia (2005); Mental Health Legislation Nova Scotia (2005); Recommended Changes to the **Hospital Act**. In particular, Proposed Improvements in Mental Health Care in Nova Scotia, what did that involve?

A. Much of that, as I think about it, revolves around my interest in mental health legislation. So as I'm sure you will be aware the definitive Nova Scotian legislation is the **Involuntary Psychiatric Treatment Act** in terms of bringing patients with mental illness into hospital against their will, so that's always been an area that I've been interested in. So

I was involved early on when I came back from my Fellowship training with discussions about changing the **Hospitals Act**, which at that time was the **Act** that governed involuntary admission, and that eventually led to the ... we just call it **IPTA** for short, so the **IPTA** legislation.

So I've been somebody who has done a number of presentations and have maintained an interest in that area ever since. So I tend to be sort of the go-to person. So if people have questions about the legislation and how it operates I'm the person that gets the emails for some reason so ...

Q. Okay. If we turn to page 3 of the *CV*, number 6 and number 7, it indicates presentations you were involved with and Application of Psychosocial Rehab in an Inpatient Setting; Psychosocial Rehab and the Forensic Patient. I guess what is psychosocial rehabilitation?

A. Well, psychosocial rehabilitation is ... it's not really a model of care but it's a conceptual model for individuals with ... we usually use it in the context of individuals with what we SPMIs, severe and persistent mental illness, so individuals with sort of severe disorders like schizophrenia and bipolar disorder, those sorts of things. So it's a model where the focus is on the individual's strengths

rather than their deficits.

(10:30)

So in psychosocial rehabilitation, you're trying to focus on engendering a sense of hope in an individual who has a chronic illness to help him or her sort of come to a conclusion that, you know, despite the fact that I've got a chronic illness, there's still things that I can do with my life and I still have value and that's embedded with general ideas of, as much as possible, respecting the person's autonomy to make their own decisions about things and those sorts of things. So it's really a philosophy of care in many ways, although there are sort of technical pieces to it that we use. But in broad context, that's what we mean by a success rate.

Q. Are you familiar with any sort of psychosocial rehabilitation models as it applies to PTSD?

A. Not specifically to PTSD, although I think a psychosocial rehabilitation model would be one that could be broadly utilized across any number of diagnostic areas. The other area that has come into interest lately, of course, you may be aware, is sort of ... our Mental Health and Addictions Program, in general, is increasingly interested in what we call trauma-informed care. So that's an area that's taken a lot of

interest in the last number of years. We've developed some models around that.

Q. So what is "trauma-informed care"?

A. Well, in general, trauma-informed care is an approach to the care of an individual that recognizes that they may have had experienced trauma in their life and that that trauma may have influenced how the illness developed. It may have influenced how they experience that illness. It may influence their relationship with other peoples and so a trauma-informed care approach takes the view that some understanding of that trauma or at least respect for that experience is essential to help the individual sort of move past the trauma, so to speak, and into more of a recovery perspective.

Q. I'm just thinking in terms of Lionel Desmond's situation where he is a military veteran and he returns back to Nova Scotia. He goes to the various professionals that treated him in Canadian Armed Forces. Is there sort of room there for building on this trauma-informed care model as it applies to returning veterans to Nova Scotia?

A. Oh, I would very much think so. I would think that for a veteran, especially a veteran that has been exposed to trauma as happened in this case, that a trauma-informed approach

would be sort of a central tenet of working with that individual. You know, that doesn't mean sort of, you know, Tell me about your trauma, over and over and over again, but simply sort of an awareness that having experienced that trauma that that's had a meaningful impact on everything from the person's presentation of their illness to their relationships with other people, and sort of an understanding of that is helpful in moving that patient forward.

Q. And what sort of professionals would that approach apply to? I'm thinking, would it apply to nurses, social workers, psychiatrists, ER physicians? Would that approach apply to them?

A. Well, I can only speak to it from a couple of perspectives. One is that certainly within our Mental Health and Addictions Program, it's an approach that we would use quite broadly across all sectors. So that would include nurses and social workers and the occupational therapists, physiotherapists that might be involved in their program. So that would be part of that. I know that in the medical school, as I mentioned earlier, I teach the Pro Comp course. So an approach to trauma-informed care is part of that program as well. To what degree it's used by specific professionals like emergency room

physicians, I'm not really sure. I mean ...

Q. And so your role as Clinical Director of Mental Health and Addictions, Department of Psychiatry, are you involved in sort of structuring and implementing ... I'm going to use the phrase "best practices or quality of care standards".

A. Uh-huh.

Q. Is there a more proper term that you may be involved in?

A. Yeah. No, that's a good term. You know, best standards. The term they like to use now is ... what am I thinking? It'll come to me, but ... yeah. So in my role at the moment, I sit on a committee called the PLT, which stands for something leadership team. Can't remember what the "P" stands for.

Q. Okay.

A. So, like I said, we have four zones, so we have four Chiefs of Psychiatry within the province, so the committee is a group of the four Chiefs of Psychiatry, the four directors for each of those zones, other policy advisers and another group of people and so we meet on a regular basis. And a part of that process, as I've said earlier, was that we're attempting to develop ... "evidence-based practice" is the term I was thinking

about. We're attempting to develop systems of evidence-based practice across the entire province that are consistent. So that's part of the work that I do in that.

Q. What is a "system of evidence-based practice"?

A. Well, so the ... evidence-based practice is the idea that what we do in medicine, in particular, as a physician is that it should be based on evidence-based practice. It shouldn't be based on, Gee, I think this works well, right, so I'm going to try this particular sort of modality, or something like that; or, I've had good experience with this, so I will do that. It should be based on ... evidence-based practice takes the view that if you're going to use a modality of treatment, there should be evidence that it's effective for what it does if it's delivered in a particular way. So that could either be medications or it could be psychotherapeutic interventions, for example.

Q. And would evidence-based practice apply to assessing risk for, say, suicide or potential for violence, moving I guess from the subjective professional opinion to more of an analytical structured model that's dependent on tools that are validated?

A. Well, one of the ... so as you may be aware, for every

hospital in Canada, we go through a process with ... it's called Accreditation Canada. So Accreditation Canada is the organization that licenses or approves hospitals. So Accreditation Canada promulgates a number of ... everybody has their terminology, so it's ROPs, Required Operating Procedures. And so in mental health, one of those is a structured suicide risk assessment. So that's an example of an evidence-based practice for that purpose.

Q. And I guess in your opinion, you're involved in a number of committees and you're in there as a director capacity. Is there sort of a desire and need to perhaps move to more of an evidence-based approach as opposed to sort of a subjective, professional opinion model?

A. Yeah. I mean when we look at ... we're striving to do two things. Right? One is that a person receiving services anywhere in the province could expect to get the same service wherever they go to a greater or lesser degree, depending on resources, things like that that are outside my control. But that service that they get should be, as much as possible, evidence based so that it's grounded in sort of clinical guidelines or it's grounded in best practices.

Increasingly, we've been trying to develop a system like

that around the province. And an example where we've adapted some of these things is from what are called the NICE guidelines. So I don't know if you've heard of NICE guidelines, but the NICE guidelines are the National Institute for Clinical Excellence. It's an organization in the UK that develops evidence-based best practices. So, quite frankly, we steal from them on a regular basis for kind of delivery of models of care.

Q. And so we're going to get into, at some point in your evidence, about tools for assessing risk and tools for assessing violence ... risk for violence, risk for suicide, risk perhaps for homicide. And your committee membership, you indicated on your *CV*, 2016 to present, Mental Health Quality Council, Nova Scotia Health Authority; 2014 to present, Mental Health Quality Council, Nova Scotia Health Authority. It's the same thing. Sorry. 2012, Mental Health and Addictions Leadership Team, Nova Scotia.

So one of the sort of assessments for His Honour during this Inquiry is to sort of take into consideration various recommendations from professionals and, at the end of the day, see what could have perhaps meaningful change in different institutions. The change, does it happen at this Quality Council of Nova Scotia? For example, if there was sort of a

recommendation that perhaps different tools might be utilized to assess for risk of violence or risk of domestic violence in a healthcare context, is that something that gets ultimately discussed at the Mental Health Quality Council that you're a part of?

(10:40)

A. At the level that I'm involved in ... maybe I'll just give you a quick review of how that process works so that I might better be able to answer your question or help me better answer your question. So within the province, we have a system where any adverse event over a certain level of seriousness is flagged. So ... and we do that through a system called SIMS, which is an acronym I don't recall the name for.

But within Mental Health and Addictions; primarily, those involve cases of suicide or attempted suicide, where there's a serious outcome. So the process that we have is one where after an event like that, we do what's called a "quality review". So a quality review is a process by which we get together, a quality review team of which I'm the co-chair of one, and then we get together the clinicians that were involved with the case.

But the focus is very much ... it's not what we would call an "M and M". So an M and M is what stands for "morbidity and

mortality". So historically M and Ms were conducted after an adverse event and the people involved with the case would get together and say, Well, you know, I could have done this, or, I should have done that; you know, that sort of thing but a quality review is at a different level.

A quality review is focused primarily on what are the systems of care and how could we improve systems of care. So it's less about sort of, you know, I could have tweaked this medication, or, I should have done this, or, could have done that, but more along, you know, Do we have a system in place to, you know, assess risk, for example, in reference to your question, or, Do we have a system to sort of follow up, for example, for patients that don't show up for their appointments and under what conditions should we do that and how would we develop a protocol for that or policy around that, those sorts of things. So it's more at a systems level kind of process, but I've been involved in that for some years now.

Q. So, Doctor, I'd ask as we go along and we move it from sort of the very broad to the specific as it relates to Lionel Desmond, I'm wondering if you could keep your hat on as it relates to quality review and systems of care sort of lens when you sort of looked at your entire review and when ... as we're

going through the questions. I anticipate it may be helpful for His Honour to sort of hear your perspectives of that lens of systems reviewed and quality of care.

So I guess just before we bring it into your actual report and the purpose for which you're here to testify today, if you could tell us just ... you're retained by His Honour to do a psychological autopsy. And I'll be honest, I hadn't heard the phrase until about a year ago. And if you could tell us what is a "psychological autopsy".

A. A psychological autopsy is a process by which you are attempting to discern as much as possible what the motive was or the thinking behind the actions of an individual who is now deceased so, hence, the term "autopsy" in the sense that the person of interest is no longer alive.

And it's a psychological autopsy in the sense that you're not interested necessarily in ... it's not an autopsy in the physical sense of that word as you would understand it. It's more sort of trying to bring a focus on a psychological understanding of the person and what may have led that person to the actions that they did and what might have been the motives behind it.

So it's a process that historically developed in the 1950s

and has been used periodically since that time, so it usually involves sort of a review of records and, if possible, sort of a review with collateral sources of information to help inform you as to what the nature of the individual was that's under review.

Q. If we could look to page two of your report, second last paragraph, you quoted Dr. Schneidman. I may be pronouncing his name wrong. It says:

> In essence, the psychological autopsy is nothing less than a thorough retrospective investigation of the intention of the decedent - that is, the decedent's intention relating to his being dead - where the information is obtained by interviewing individuals who knew the decedent's actions, behaviour, and character well enough to report on the matter.

Is that, in essence, what you're conveying here today, that that's the purpose, in essence, behind a psychological autopsy?

A. Yes. And that's what I've attempted to do throughout the course of my report, so ... yes. It's a review of the documentation and review of information available to me along with some collateral interviews to sort of, you know, to use the

vernacular, sort of probe the mind of the individual that's no longer with us as to what his intent was at the time.

Q. Okay. And we're going to get into it. It sort of dovetails into this other area that you commented on about criminal responsibility that's set out in the **Criminal Code** and your experience there. I guess from a forensic psychiatrist's perspective, what is an assessment for criminal responsibility?

A. Well, from a forensic psychiatry point of view, when I do an assessment I do it in essentially two steps. So the first step is ... and these are usually done in the context of a court-ordered assessment, so normally, we have assessments at the East Coast Forensic Psychiatric Hospital that are brought to us under Section 672 of the **Code** which is the assessment-ordered component of the **Criminal Code** for court-ordered assessments.

So the first step is to determine whether or not the person has mental disorders. So a mental disorder ... or as lawyers like to call it, a disease of the mind, as they would say, is quite broad. But for our purposes, my first step is to determine whether the person has a mental disorder, so ... then my next process after that is I look at the information available to me with respect to the alleged offence that the individual has committed.

And then the task of the forensic psychiatrist is to, as much as possible, get information from the accused as to what they felt their motives or intent were at the time in as much as they are willing to share that with you, which isn't always the case of course. And then compare that with the evidence or information available that's given to us by police and other services to see whether at the time of that event, the person meets the criteria under Section 16, which is ... you're probably aware is that a person is not responsible for an offence made or omission ... I can't remember the exact words, if at the time they suffered from a disease ... mental disorder such that they were unable to appreciate the nature and quality of their actions or to know that they were wrong. So that's the phrase.

So we look at that in one of two ways. So the "unable to appreciate the nature and quality of their actions" has been defined in Canadian law quite narrowly. So it's usually, you know, Did you know that if you poked this guy with a knife that that was going to put a hole in the guy? Right? It's fairly straightforward. The moral component is often the more intriguing one in the sense that it encompasses both legal and moral wrongfulness. We've had a number of cases at the hospital

where an individual is found NCR based on that component. So the most common example would be somebody with a psychotic disorder who feels that they've had to do something because God told them to do it, so who's going to disagree with God; or, you know, that it will bring upon a new kingdom or, you know, all those sorts of things. So those are the focus that you have as a forensic psychiatrist in doing that sort of assessment.

Q. So you're doing an analysis which is a nexus between a recognized mental health disorder and assessing the person's intent.

A. Correct, yes.

Q. And, Doctor, how many criminal responsibility assessments would you estimate that you've done in your 20-some years as a forensic psychiatrist?

A. I don't keep count, but ... as I always say when I'm asked this question, we do about 200 a year at the hospital, so I've been doing them for 20 years, so ... to do the math, what's that?

Q. It's a big number.

(10:50)

A. We do those on a rotating basis, so I don't do them all, but ... so I've done several hundred, I would think by now

certainly.

Q. And part of the reason why I'm asking you a little bit about what you do in a not criminally responsible assessment, an NCR assessment context, is I'm trying to relate it to the concept which is ... or the practice which is a forensic autopsy. Are they similar and, if so, I guess how do they differ? Is your approach much the same or is it different?

A. The approach would be the same. I mean the biggest difference, of course, is that one of the major sources of information, that is the person themselves, is no longer there to provide the information to you. So there's an inescapable sort of point where you come where, in the end, you can never truly know what the person's intent was because you weren't with the person at the time that they committed the offence. Right? So ... and the person is no longer there to explain what their intent was, so it ... to my mind, it requires a certain level of making assumptions that isn't necessarily the case in forensic psychiatry where you have an accused that's still available to sort of be interviewed.

Q. Okay. And the practice of conducting ... I should ask you, I guess, how many psychological autopsies have you been involved in?

A. Very few, actually, because I can't remember the number, but ... because the ... like I said, we do the quality reviews on all suicide deaths that we do. But because we're doing them from a systems point of view, we're not really focused on sort of what was the intent of the person in taking his or her own life. It's usually, honestly, quite self-evident. And so in that sense, it's ... and because the original psychological autopsies were done in the context of trying to decide about an ambiguous step, whether it was an accidental death or whether this was a suicide or those sorts of things, most of those cases don't come across to us. Those are mostly dealt with through the medical examiner's office. So that would be Dr. Bowes' office so ...

Q. Okay.

A. I've had some conversations with Matt about these things but other than that ...

Q. Okay. And the practice of a psychological autopsy, is it something that's recognized within the community of forensic psychiatry as in sort of accepted practice and in terms of its reliability?

A. Well, it's certainly accepted within forensic psychiatry as a technique and a structure. So there's several

papers written on this in the forensic psychiatry literature. The question of reliability would be a difficult one to answer because I don't know that there's been any large data sets. Because, again, you're facing at the end, sort of a brief moment of unknowability, so to speak, in the sense that you can't collect data about what the intent of a person was because, in the end, you're still making assumption about what the intent was. So it would be hard to collect data for that purpose. But the technique is widely applied to forensic psychiatry.

Q. Okay. In terms of your role as a forensic psychiatrist ... I guess I should start by saying, how many different types of mental health disorders have you seen in the context of doing an assessment for criminal responsibility? I guess if you can give us a general sense, sort of major depression, schizophrenia, bipolar, have you seen all of those in the context of ...

A. Well, not to be trite, but if you could name it, I've probably seen it. But, yeah ... no. So we see ... it's probably easier to group it into sort of some of the major categories that we see.

Q. Okay.

A. So we see a lot of individuals with what we would call

the serious and persistent mental disorders. So those are things like schizophrenia and bipolar disorder, schizoaffective disorder. Those are a common population of individuals that we see. We see individuals with anxiety disorders, for example. Another large population that we see are individuals with substance use disorders. That's a common group that we see.

We often see individuals with personality disorder. So the big groupings there would be antisocial personality disorder and borderline personality disorder, the common ones we would see in that setting. We've seen some individuals with autism spectrum disorders, for example. So we can sometimes see members of that population. So it's a fairly wide spectrum of individuals.

Q. What about someone with a similar profile to Lionel Desmond, which is PTSD coupled with major depression, mixed personality traits?

A. Yeah. We've seen, over the years, a fair number of individuals with PTSD. And, as we were talking earlier, I mean inasmuch as we're now increasingly interested in sort of a trauma-informed approach to care that it's ... when I do see individuals, I'm conscious that I explore with them some of the trauma that they've experienced because that often sets the backdrop to some of the behaviours that they've been engaged in

and for which they're there for an assessment.

Q. If you'd give us a sense of ... you're seeing someone with the profile of Lionel Desmond and you're assessing them. Why would it be important to sort of get a sense of the history of his trauma, whether it be military, whether it be race-related, childhood-experienced trauma? Why is that important?

A. Well, the way I tend to think about it is those kind of features in a person's background have an impact on who they become as a person. So, for example, an individual who has had repeated traumas in their formative years, whether those are ... as we've said, whether that's physical trauma or whether that's through issues of racism or harassment for other reasons, and those sorts of things, that can impact on a person's development so that, for example, if I see that person later on and I'm struck with, for example, you know, they don't seem to be very resilient. They don't ... they can't roll with it, so to speak, right, you know, so that they have trouble letting things go or they're angry about all sorts of things.

So it's ... you know, the trauma approach to care would sort of lead you to think that, Well, those traumatic events have had an impact on why they're not resilient, why they're so angry and that sort of thing and that would become, in some

ways, the fodder for therapy if you were doing therapy with that person.

Q. Okay. So I want to get into sort of the foundation of your report or what I've sort of generally sketched out as the foundation of your report. If we turn to page two, at the very last paragraph, Doctor, it appears as though very early on in your report you sort qualify the scope of your review. It says, "Readers of this report are advised that some areas of the Inquiry outside this scope ..." I'm just wondering if you could explain why you qualified and what was the purpose behind qualifying your report to a certain area.

A. As we've discussed, my report has really been focused on sort of the tenets of a psychological autopsy. So that really is focusing on the clinical aspects of the individual and sort of their development over time and what led them to make the decisions that they did at the end of their life, of course, so in this particular Inquiry there are a number of other important issues. And, to some degree, they can't entirely be separated, but ... so as I'm sure the Inquiry has canvassed, there's been lots of issues about sort of information flow and who had what information when, you know, all those sorts of things. And we've had some discussion about how that can inform

the clinical practice. But to the degree that that's a question in and of itself, that's really not addressed in this particular report, for example.

Q. Okay. So would you agree that sort of the foundation of any expert report or foundation of any forensic psychiatry report is based on the facts that you are given? Is that a fair ...

A. Yeah. It's based on the facts that you're given and to some degree, when you read through clinical notes, your interpretation of sort of that information which is a little more subjective and not so much fact based, you know.

Q. Okay. So in addition to sort of the facts and reading the sort of ... the clinical information you were provided with, what other sort of areas did you draw from in formulating ultimately the opinions you did? What sort of areas did you draw from, professional experience, research articles?

(11:00)

A. Well, I did canvass a number of research articles, as you can see through the body of the report. So I did utilize those in the report where I could. I've drawn on the factual information that's given to me. I've drawn to the extent that I could on some of the testimony that was provided. So I've used

all those resources and, as I've noted, I had some conversation with several witnesses. So that formed part of ... In the end, I'm trying to draw a synthesis of sort of a hold the data together, so to speak.

Q. So I guess we see from pages three to 13 of your report, you do a synopsis of portions of the facts that you found relevant, is that correct?

A. That's correct.

Q. And then there was a comprehensive list of documents that was attached to Appendix A. Those are the documents that Inquiry staff had forwarded to your attention for a comprehensive review. So you've reviewed the contents of all those documents as outline in Appendix A?

A. I have. I would like to tell you that I read each and every page but that wouldn't be honest.

Q. Okay, okay. So in terms of the materials that you were provided with and the facts that you reviewed, are you able to say whether or not you are confident in your opinion based on the level of facts that you were provided with?

A. I think based on the level of facts that I have, my understanding of Mr. Desmond and, ultimately, what happened on January the 3rd, 2017, yeah, I'm confident in my opinion on the

matter.

Q. You indicated you interviewed a number of people above and beyond the facts that were provided to you. Do you recall who you interviewed?

A. I interviewed Cassandra Desmond, so that would be Mr. Desmond's sister. I interviewed Thelma Borden, that would be Shanna Borden's mother. And I interviewed Cpl. Orlando Trotter, who was a personal friend of Mr. Desmond's.

Q. If you could just indicate what was the purpose for, above and beyond what you were provided, what was your purpose for reaching out to those particular individuals?

A. Well, I probably ... two things come to mind. So one is that I was interested particularly in talking to Ms. Borden and Ms. Desmond, trying to get sort of the ... let me put it this way. There's lots of information about Mr. Desmond after he comes back from deployment and sort of the difficulties that he had. So I was interested in trying to contrast that with what information we had about what he was like before deployment. So, to that extent, I was interested in some information about other individuals' understanding of and view of Mr. Desmond before he was deployed and what kind of individual he was like at that point. Because that has value in

terms of thinking about how mental disorders develop, how things like personality disorders develop, which is an issue that comes up in the course of the materials. And Cpl. Trotter was valuable because he's an individual that has both, if you want to think of it this way, a pre- and post-view of Mr. Desmond, before he goes on deployment, while he's in the field, and then when he comes back. So it's useful information to help sort of understand Mr. Desmond over time.

Q. I have a series of questions that are going to be sort of based on the facts themselves. If we look to page five, paragraph four, in that paragraph, you indicate there are some discrepancies in the description of Mr. Desmond's early formative years. So I'm just going to sort of ask you there as a starting point, there seemed to be, you reported that there was a discrepancy on facts. What was that discrepancy?

A. Well, in my discussion with Cassandra Desmond, she indicated that, as I've noted, she portrayed the formative years for Mr. Desmond as generally positive ones. That stands in contrast to some of the other information that's available by review of records. So there were psychiatrists, Dr. Slayter stands out as one where he had told individuals that his growing up was tough and there's various documentation to a greater or

lesser degree as to whether he was subject to any physical abuse during his early years. There's history, of course, of systemic racism in Nova Scotia and Mr. Desmond's exposure to those sorts of things. So those are all features which, as we've talked about briefly, can help sort of influence the development of a person over time. So there seems to be some discrepancy between some of the perspectives of what he was like as a person prior to his joining the Canadian Armed Forces.

Q. And I believe you indicated that there was documented evidence from one of the reports that indicated that he had reported being subject to both verbal and physical violence in his formative years.

A. On page five, I've noted a note from Dr. Joshi who noted, "Cpl. Desmond describes his childhood as difficult. He experienced severe physical and verbal abuse." And above that, the note from Dr. Slayter who described his growing up in Lincolnville as "tough".

Q. And sort of, Doctor, I guess, how at the end of the day did you sort of reconcile that discrepancy? It appeared to be noteworthy, I guess, you put it in your report, but how did you reconcile it in the end when you were going through your analysis to reach the ultimate opinions that you did?

A. Well, it's an interesting point for discussion because you have an individual whose reported early life has these discrepancies that I've described, yet is generally described by people that knew him, including Cpl. Trotter, as being a happy-go-lucky guy, I think the phrase was, or those sorts of terms. And then post-deployment develops PTSD. So we know that early trauma experiences are a risk factor for development of PTSD. So that would be a potential sort of area of interest in terms of discovering more about it because that might inform why an individual like Mr. Desmond ultimately developed PTSD based on the exposure that he had where other people don't, for example. So it's useful information to sort of understanding the contextual background for the development of the disorder that he eventually developed.

Q. Were you able to see sort of anywhere in the documentation, it's reported sort of, I think the exact words were, it says severe physical and verbal abuse when he was younger. Through the records, did you ever see any sort of deeper dive into those issues as it relates to Lionel Desmond and in terms of trying to apply it and treat that as above and beyond sort of he has PTSD now but looking at sort of root things early on, did you see any indications that that was ever

sort of assessed or treated in any way?

A. Not that I can recall, although I would say that that would certainly be something that would be often explored in individuals sort of working within a trauma-informed framework. So for somebody like Mr. Desmond, you would probably want to treat sort of the most overt traumas first, you know, the traumas had occurred during sort of his deployment and those sorts of things. But then once that was under reasonable control, then you would probably explore with him, you know, frankly, do you want to open up this can of worms so to speak, do you want to talk about earlier traumas in your life, or is that something you don't want to talk about. You have to leave sort of the decision ultimately up to the individual themselves, of course.

Q. And, in your opinion, and I know it's maybe perhaps a little difficult because you don't know the full extent of what that severe abuse was that was reported by Mr. Desmond, who it was by and what context and for what duration you do not know. Is that something, in your opinion, that could sort of play a role in the psychological portrait that was Lionel Desmond in January of 2017?

(11:10)

A. Well, those kind of events occurring early in an individual's life can have fairly profound effects on personality development. So the one that I've seen most commonly is that an individual exposed to those kind of traumas or experiences, it creates difficulties in them assuming that an environment can be trusting or trustworthy. So that they come to question the motives of other people, whether people are being genuine or not, whether people sort of have their best interest at heart or sort of, to use the vernacular, you know, like they're always waiting for the other shoe to drop so to speak so ...

Q. In terms of the records themselves, I guess even pre-military, we have various Health Authority records of him attending the hospital in Guysborough for an injury to his eye. Were you able to see any sort of indication of any information that there was ever an structured sort of diagnosis and treatment as it relates to, I'll call, childhood or adolescent trauma?

A. Not that I was able to see, no.

Q. I'm sort of interested in your comments as to ... you talked, and we will go through sort of the risk factors for developing PTSD, and especially as it related to Lionel Desmond.

But what is your opinion with respect to what role severe verbal and physical abuse might have played in his, I guess, vulnerability to develop PTSD after his combat experience?

A. Well, that would be exactly how I would think about it. So in psychiatry, in general, we think of any disorder as having predisposing, precipitating, perpetuating, and protective factors, the four Ps that we teach the residents. So for somebody like Mr. Desmond, if he had traumatic experiences growing up, that's what we would consider predisposing factors. Because it can help shape an individual's sort of internal thought processes about how they experience the world such that when a precipitating factor occurs, like the trauma that Mr. Desmond experienced while overseas, that that combines with the predisposing factors and creates the grounds on which the disorder develops, right. So that's the importance of those sorts of materials.

Q. Does that sort of, I guess, pre-existing trauma pre-PTSD, can it play any role in sort of the, I guess, persistency or the chronicity of PTSD symptoms currently? So, for example, Lionel Desmond was exposed to trauma in the military. But he also was exposed to trauma as self-reported before the military. Do those two things, I guess, blend together to form sort of ...

can form, can become more of a persistent chronicity in PTSD symptoms that he's showing? I hope that made sense.

A. I think they could lend itself to a chronicity. Because for individuals with PTSD, one of the factors that relates to (1) whether they develop PTSD, and (2) how chronic it becomes as to what degree are they resilient. We talked a little bit about being able to roll with things and there was some evidence that Mr. Desmond was not able to roll with things. So that's, in my opinion, likely a function of both the trauma experiences as he had a member of the Armed Forces but some of these earlier experiences as well. So they acted in concert to sort of reduce his ability to deal with things in a resilient sort of problem-solving fashion, which comes out in much of the documentation about Mr. Desmond and would lend itself to sort of chronicity of symptoms over time.

Q. So healthcare professionals that would have interacted with him much later on, say in 2015, Dr. Murgatroyd, for example, 2016, how important in Lionel Desmond's profile is it to sort of try to zero in on that information and gather up information about that pre-PTSD trauma when you're trying to treat a PTSD symptom that may be a flashback connected to the military?

A. It would be important, although I would ... One of the issues that often comes up in therapy and I think, as I think about sort of some of the materials that I've read, one of the difficulties that Mr. Desmond had and the professionals that were dealing with him had, was that much of the work was often very crisis-driven. It was sort of the problem of the day, you know, I'm having difficulties with this, I'm having difficulties with that, which is part and parcel of everyday life, of course. In order to sort of still the waters, so to speak, a lot of effort goes into just sort of calming the individual and sort of problem-solving around those particular issues. So consuming that amount of energy leaves very little time left to sort of deal with sort of earlier issues.

The other risk would be that by doing that, you inadvertently sort of make the situation worse by now having the person sort of ruminating about not just sort of things in the here and now, things from what's called the sentinel trauma, but earlier issues as well. So it's something you would need to be cautious about in terms of the timing of when you would want to introduce, but it would be an important thing to get to at some point in therapy.

Q. And I'm certainly mindful that everyone that we've

heard from, especially as it relates to physicians in the ER. I am thinking of Dr. Rahman, Dr. Slayter in his clinic, certainly, especially, I guess, Dr. Rahman, Lionel Desmond presents in a crisis in a moment. He discloses issues with his wife, not to go home, find another place, he's there, he's overwhelmed. I guess I'm wondering your comments on sort of the difficulty being in that sort of position when, other than the moment of crisis, there's everything below it. How do you manage that without just sort of temporary, I guess, masking things in the moment, dealing with the current crisis and getting at the underneath. And did you see whether professionals along the line were able to get at everything under the water, I guess?

A. It's a very good question and I mean, like I've said, it's something that you do have to ideally tackle in therapy at some point. Again, some of this is contextually bound in the send that there are times when you want to deal with that issue or at least identify it as an issue to be dealt with later and there are other times where you either aren't able to by course of time or because your decision-making process is constrained by other sort of things like immediate decisions that need to be made. So I think that one of the things that strikes me is I think about in Mr. Desmond's case is that and as I think about

trauma, in general, is that we ... There's still a lot of stigma about these sorts of issues, particularly within military culture. So the idea of you don't talk about things, you don't sort of raise issues. There's often a reluctance for people to raise these sorts of issues about, especially if they had early life traumas because they may see it as embarrassing or shameful of those sorts of things. So those are difficult to get at in the course of a brief contact with somebody and usually requires a more developed rapport with a person so that they feel comfortable in doing that sort of work.

Q. Were you ever able to, in your review, are you able to comment if professionals were ever really ever able to gain traction of consistently, rather than just putting out immediate crisis fire, whether or not they were able to break down and start to get at the underlying source of the immediate crisis. Did you get a sense whether professionals were ever able to get a full handle on that?

A. I think that the relationship that Mr. Desmond had that was probably the one in which he had the best rapport in which there was a considerable body of work done was when he was still an active service member and he was seeing the psychologist through that program whose name is ...

Q. Dr. Rogers?

A. Dr. Rogers, yes. So Dr. Rogers had done a lot of work with Mr. Desmond and much of that was sort of the standardized kind of sort of processes that they use, you know, exposure work, those sorts of things related to the particular traumas that he had experienced while during deployment. But my sense of it was that once that piece of work was done, then Mr. Desmond was returned to sort of more general services. So it didn't really get into any sort of deeper sort of issues of pre-existing trauma or difficulties in earlier years that might have sort of been helpful.

(11:20)

Q. What do you think in terms of reviewing now, what do you think was the reason behind perhaps why Dr. Rogers seemed to have the level of success she did compared to others with Lionel Desmond and his symptoms?

A. Well, Dr. Rogers was able to see Mr. Desmond on a weekly basis, as I understand, over a long period of time. By dint of contact, that was helpful, I think. But I mean over and above that, I think that, and I've never met her, but her therapeutic style was, we've talked about evidence-based practice, and that was the approach that she used was certainly

an evidence-based practice. So that, I think, helped Mr. Desmond focus on what some of the tasks were in terms of sort of the progressive exposure, prolonged exposure models and stuff like that that she was working with him on.

Q. So is it fair to say, if I was to summarize, would it be the success with Dr. Rogers in your view was consistency, seeing him very frequently, and using an evidence-based practice?

A. Consistency, evidence-based practice, and sort of at the core of it, I think as well sort of a sense of a rapport with a person is necessary in order to advance in therapy. To some degree I think that Mr. Desmond also had that with Dr. Murgatroyd because he seemed to be in fairly regular contact with Dr. Murgatroyd, although much of that was by phone rather than meetings so less frequent hands on.

Q. So when Lionel Desmond gets to the community after he leaves the military in 2015, did you see in your review that sort of approach continued, which was rapport, consistency, and evidence-based treatment? Once he leaves the military, do you see that continued?

A. I'm sort of going through them in my mind. So he leaves the military and then he is connected with the OSI Clinic

in Fredericton.

Q. Yes.

A. And that's where he establishes his work with Dr. Murgatroyd, which I don't think had the frequency of contact that it did with Dr. Rogers. So that's one point. The psychiatrist involved, Dr. Njoku, sees Mr. Desmond relatively infrequent. That's not unusual in that much of the work for post-traumatic stress disorder is related to psychotherapeutic activities and not sort of pharmacological activities. So it's not unusual for a therapist ... a psychiatrist to see somebody very few months to tweak their meds and see how they're doing and that sort of thing.

But in the work that he did with Dr. Murgatroyd, like I said, much of it seemed to be more crisis management, if I could use that term. So sort of managing with the issues of the day so to speak, which increasingly come to and encompasses concerns about his wife and issues related to that and eventually sort of moving him in a direction towards where he goes to Ste. Anne's.

So, in that sense, there's two things that come to mind. One is that some of the work that he had done with Dr. Rogers, where she had noted that he was doing much better, seems to unravel, so to speak. So that he's more stressed out. He's

having more difficulties. Some of that seems to be related to recurrence of his PTSD symptoms. Some of that is related to these other stressors that he's contemporaneously trying to deal with at the same time. So that becomes part of the clinical picture as well there.

Q. Do you think Lionel Desmond could have benefited from, I guess, a Dr. Rogers in a community setting in a sense that he has a consistent routine sort of weekly, much like Dr. Rogers, professional presence that was engaged in those three things - rapport building, evidence-based approach, and the third was ... I lost it. But do you think ... Consistency. Do you think that might have been, in hindsight on your review, do you think that would have been valuable and needed for Lionel Desmond?

A. Well, I think it would have been valuable. I mean the question of whether it would be needed or not would depend, to some degree, on ... because, in the end, you have to sort of grant an individual the dignity of autonomy in terms of what they want to work on, right. So, you know, so consistency in sort of following him after he left the military would be useful.

And I think that could be done in one of a couple of ways. So often in our programs what we have is we might have an

individual do an intensive group, for example. An example that comes to mind, which is sort off in left field but just as an example. So sex offenders, right. So you often treat sex offenders in a very sort of concentrated form. Sort of multiple sessions over many weeks and sort of work with it that way. And then they move into more maintenance phase. So rather than see them as intensively, you see them on a regular basis but it's really to maintain the gains that the person has, right. And then if those gains slip away, then you sort of ramp it up again, so to speak, in terms of your contacts with the individual so ...

So, with Mr. Desmond, he had done good work with Dr. Rogers but when that slipped, there either wasn't the ability to or, at least it didn't happen. There wasn't ... it didn't get stepped up again in terms of the frequency of contact.

The short answer to the question is it depends on where the person is in the moment but sometimes you need to step up or step down your contact with an individual based on where they are in the moment in their lives and what they want to deal with as well.

Q. And, in your opinion, were there points post-military where there were opportunities to sort of step up that presence?

A. I don't know a lot about the structure of sort of how things work in Veterans Affairs. I mean I do know a little bit about the OSI clinic structure. Ideally, for a veteran, the OSI system is a resource in a way that it at least provides the ability to sort of increase that kind of resource base so that the person can have more access to services.

Q. We're going to get into a little bit more as we move along. I want to sort of ask you about any sort of impressions or opinions you formulated as it relates to Lionel Desmond's, where he stood in terms of, I guess, support from families and how the relationship was between the Bordens and Desmonds and what, if any, impact that might have had on Lionel Desmond.

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

Dr. Theriault, we normally take a morning break and we're just a little past when we would normally take it, but we are going to take a break for maybe 15 minutes or so. So let's try and come back maybe about 20 to, quarter to, 20 to, perhaps, all right? Thank you. Thank you, Counsel.

COURT RECESSED (11:28 hrs.)

COURT RESUMED (11:46 hrs.)

THE COURT: Thank you. Mr. Russell?

MR. RUSSELL: Thank you, Your Honour.

So, Doctor, where we left off, it was a question as it relates to you had interviewed a number of family members and you reviewed a number of statements and the file in its totality, I guess. There was a relationship that was the Desmond family and the Borden family and Lionel Desmond. Did you get a sense of how his relationship was with the Borden family and Desmond family in a general sense?

A. Well, broadly speaking, the information that I had would suggest that there were a number of sort of ongoing issues between the two families. So when I had spoken to Cassandra Desmond, I was curious because, early on in my review, there was a passing reference that Mr. Desmond had planned to be married, and then one of those, sort of, just didn't show up at the altar, so-to-speak, kind of situations. So, in exploring that with Cassandra Desmond, she had indicated that there was concern amongst the family members that it turns out that Shanna Desmond and Lionel Desmond were distantly related, and so that was a source of some sort of concern within the family. And then they were married in a civil wedding, so that sort of was another issue.

There was issues, as I understand it, having to do with

sort of the Desmond family's concerns about some of the Borden family members; particularly, Ricky Borden, who, as I understand it, has a criminal record. So there just seemed to be sort of an ongoing - and I don't have the details of it - but sort of an ongoing sort of, whether it was hostility or just a sense of disenfranchisement between the two groups that continued on over many years. And when you look at my report, you can see that one of the comments was that when Mr. Desmond went to visit, that he wasn't able to visit his side of the family, and, on the other side, concerns about how ... reports from Thelma Borden that Mr. Desmond had sort of cut off his side of the family because he didn't like the way that his siblings treated his mother.

So whether those are accurate or not is not so much the point. It's simply that, for an individual with a chronic mental health illness, the level of social support that they enjoy is very important to their success and there just ... there seemed to be, quite apart from the issues that Mr. Desmond may have had with Shanna Desmond herself, that there were just sort of these animosities between the two sides of the family that collectively meant that, as a broader family unit, being able to come together to support Mr. Desmond, that that was

sorely lacking.

Q. And, certainly, Doctor, I want to make sure that the record is fair to you and fair to both wonderful sides of the family. If we look to page 6 of your report, the fourth paragraph from the bottom, I'll read this into the record and maybe ask you a brief question about it, but you say: "I raise this, not to judge the veracity of either side, but only to suggest that as a result, Mr. Desmond did not have a balanced, widespread base of family support."

(11:50)

So is that sort of what you're saying here today?

A. Yeah. My intent in bringing it forward in the report isn't to sort of make aspersions towards either side of the family - I certainly wouldn't want to do that - but simply to say that because, collectively, there seemed to be issues there that have been ongoing for some period of time, that inasmuch as sort of having a solid, social support environment around you, and that includes your immediate family members as well as your extended family members, can be important in someone's recovery from a mental health issue, or any health issue, for that matter - that that seemed to be lacking in this instance.

Q. Okay. Again, sort of your overall impression based on

facts. I guess I would title it sort of "Changes in Lionel Desmond Following Military Deployment". And here, you had indicated you had an opportunity to interview Cpl. Trotter about his interactions with Lionel Desmond, and it's on page 6 of your report. I guess, if you could tell us a little bit about the value of information you gained from Cpl. Trotter as it relates to sort of understanding Lionel Desmond's complexity of his psychological profile.

A. My conversations with Cpl. Trotter were important, I think, in two respects. One is that Cpl. Trotter had said that his early impressions of Mr. Desmond were that he was a likeable, easygoing, sort of guy, that, you know, he was outgoing, social, those sorts of things. These observations that he made of Mr. Desmond well in the field were, to me, suggestive of early indicators of a change in Mr. Desmond's sort of psychological understanding or view of things so that he had referred to his friend as becoming quiet or distant. So that would suggest to me, as a clinician, that that might've been an early sort of, could we say, red flag about sort of potential issues to come? So it's important in that regard.

Q. In terms of Cpl. Trotter mentioned, in his words, sort of he indicates that they broke up the team. What was he

referring to there?

A. My understanding, and correct me if I'm wrong, is that they broke up the operating unit that he was with.

Q. And, sort of, did you get a sense of how valuable - knowing Lionel Desmond's condition and his life as he left the military - how important it was for him to perhaps have a sense of camaraderie and team of people that were maybe similar to him in many ways, that he would confide in and be a social support? Is that something that you saw that would be important to Lionel Desmond?

A. We certainly know from review of the literature that exists on PTSD in military populations of which there's a great deal, of course, because that was where PTSD first really came to prominence as a disorder - that in military culture - and I can only speak generally to this because I don't work with that population generally - identification with your peers is an important part of the social network, the social solidity that you have. And so, to the extent that that's true, having individuals sort of remain in units where they have peers that they respect and sort of feel that they can talk to about things is an important component of helping the person deal resiliently with issues that have happened, and it provides sort of an

impartial sounding board.

I mean when I have talked to military members, you often will hear the phrase, you know, You have to have been in the military to understand the military, or phrases like that. So to the extent that you understand and respected the unit that you were working in, and that becomes a sort of a significant source of not just comfort but, in some ways, a significant source or problem-solving.

Often, when we do group therapy work and in the work that I've done, it's largely with offender populations, for example, because I'm a forensic psychiatrist, it's very useful to do that in a group setting because, quite frankly, what will happen is the group of offenders will call one another on things, like, you know, excuse my language, they'll say, Well, that's bullshit, right? You know, or that sort of thing. So it's a useful tool to sort of provide support and have people sort of approach things in a realistic kind of way.

Q. We've heard evidence from Dr. Smith in New Brunswick about how he saw the importance of Lionel Desmond, when he would be around the clinic and he's interacting with his peers, and how important he felt that that sort of interaction, much like you were saying, is beneficial to a veteran. In Lionel Desmond's

case, do you think there was a sense of isolation, I guess, when he was in the community after he left the military?

A. Very much so. And I think probably even some sense of that when he was still in the military because when I had spoken to Cpl. Trotter, I mean, because he wasn't in the unit anymore and he was put in a different work location, he, as I'm sure the Inquiry will know, this has been canvassed, that he had a number of other work-related issues which, at times, became a significant source of concern for him, dealing with racial issues and harassment. So, in that sense, he was already feeling isolated.

And then after he leaves the military, his ability to connect with members that he was familiar and comfortable with would've been even further impaired. Part of that was, of course, because Mr. Desmond came back to this rural part of Nova Scotia where, honestly, there's probably a few veterans like him in the community, and part of it was he wasn't connected with our OSI Clinic in Halifax, although, to the degree that he would've known anybody there, I don't really know.

Q. So putting sort of your quality control or lens on and applying it to Lionel Desmond's profile, do you see if there would be any value in sort of a structured peer support for

someone like Lionel Desmond? And I'm mindful of the fact that he is in rural Nova Scotia, but when he transitions from military and he's back out into trying to navigate what it is to be a civilian again, in terms of a psychosocial, I guess, rehabilitation, is there value in having maybe a structured peer support where there is a group of people that he can meet with that share experiences, that share that support and, as you referred to it, to be able to almost call each other out on things in a way that they understand? Is there a benefit to that in a therapeutic sense?

A. I think there would be. I mean we know that we were talking a minute ago about social supports generally, so in the context of family, but this is social support in another venue; sort of a social support with a network that he had come to know in the context of his being a member in the services. And we certainly know that peer support programs are very important in our recovery models. We employ several peer support workers throughout the province that support individuals in their recovery from mental illness, and they're always individuals that have, themselves, had a mental disorder, so that it allows you to sort of, you can identify with the other person more easily and you don't have to ... there's no - to use sort of a

well-worn phrase - no judgement, right? You know, you are who you are in that context and so it would be very helpful in that sense, I would think.

Q. And you said that the province currently has some models of peer support?

A. We do. They're primarily for our SPMI populations, so individuals with severe and persistent mental disorders but we do have some models of peer support.

Q. Can you see some benefit in maybe the province having a peer support geared specifically towards veterans and their rehabilitation from mental illness coming out of the military?

A. Yeah, I think it would be a very interesting idea to explore. I mean you get into, and this is something that I didn't tackle in my course, which is the relationship between sort of different structures, you know, VAC versus the Health Authority and all those sorts of things, but, as sort of a general idea, I think it would be a very good one.

(12:00)

Q. So I guess if you take the concept and say, you know, At its core, Lionel Desmond, he's not only a member of the military, but he's also a citizen of Nova Scotia. So at some point, he's returning to his home province, which is Nova

Scotia, and there's naturally a tendency, he's going to have to lean on the resources that our province can provide him in a healthcare context. Do you see some way in which, and I know it's putting you on the spot without giving all the details, but a way in which a social support can be set up for military veterans early in their transition once they leave the military? That sort of the province takes a lead role in that?

A. We certainly have the machinery to do it in the sense that we have sort of the various disciplines and resources throughout the province to do that. You would have to ... If I were going to do this as a project, for example, you would need to be very clear on what level of support that would entail, you know, because that's sort of a truly therapeutic endeavour or is it more sort of a social sort of maintenance and support kind of model? You'd need to know what volumes to expect because then you have to resource it and all those sorts of things. You'd have to figure out basic operational things like, well just like location, for example, and stuff like that, although ...

THE COURT: It could just be another project to explore. You put a committee together, you have meetings, you get all the people that can offer input. You get them sitting around a table, they have a discussion. They could discuss all of those

things, couldn't they?

A. They certainly could, yeah.

THE COURT: No reason why they couldn't. We do it; that is, the Province does it, for a whole variety and a whole range of activities. Sorry.

A. And one of the things that just occurs to me just as we're talking about that is that one of the upsides of the pandemic, if there is such a thing, is that we've become much more fluid in using the resources available to us, particularly in the virtual realm. So, for example, arguably, there would be no reason why you couldn't have a social networking group of veterans that utilizes technology rather than sort of everybody being in the same room together, right? So we do a lot of our assessments virtually now.

MR. RUSSELL: So there are creative ways, I guess, you can rely on an aspect of psychosocial rehabilitation involving individuals that are there as peer support.

A. That's correct, yeah.

Q. Okay. In terms of the other aspect of your interactions with Cpl. Trotter, he indicated that he believes his friend - at the last paragraph on page 6 - that his friend felt increasingly isolated. And then you said: "He also

indicated that he became more complaintive about the people that he was working with, sometimes suggesting racism was involved."

I guess if you could tell us a little bit about what Cpl. Trotter had relayed to you and how that sort of came about. So, clearly, he indicated to you and must've felt it was important in some way.

A. My recollection of the discussion really is that he felt that Cpl. Desmond, as he was at that point in time, had become more isolated and more irritable, and that was showing itself in the work environment, and that some of those issues related to complaints about racism. So Cpl. Trotter didn't ... and I don't have any comment about the validity or not of those concerns. I know that they did go forward to sort of Mr. Desmond's supervisors and such at the time, but I think it's, in general, it's just his observations that there was a distinctive change in his friend from the individual that he'd known pre-deployment.

Q. We talked a little bit about, we got your views on sort of the complexity that was Lionel Desmond and, through the report, it was more than just a man that went to the military and he has PTSD. We talked a little bit about childhood trauma. I'm curious to know sort of the potential aspect of racial

trauma because we know that there was a reference in CAF that, and I can't remember if it was Dr. Rogers or Dr. Joshi, but they indicated that a racial incident had sort of triggered his PTSD symptoms or aggravated him in a way. If he's harbouring these experiences of perhaps racial trauma to some degree, how would you say that is interacting with his psychological profile?

A. Well, there's, of course, an ever-growing literature on issues related to individuals' experiences of racial trauma and everything from microaggressions to sort of full-blown sort of issues. It can impact on an individual in a number of ways. So as we talked about, for someone like Mr. Desmond, it could impact on that sense that I mentioned about sort of, Who can I trust? Who don't I trust? Do people have my best interests at heart? Those sorts of things. And, honestly, frankly, you know, in some instances of racism, people don't have your interests at heart. They have their own sort of motives for the things that they do and stuff like that. But those kind of experiences could just lead somebody to question everybody's motives about sort of the interactions with others, which, inasmuch as one of the symptoms of PTSD is your view of the world as being a changed place so that it's not safe or trustworthy and stuff like that, it could exacerbate those kind

of symptomatologies.

Q. We've heard testimony from Shonda Borden that when she lived with Shanna, her sister, and Lionel in New Brunswick, and she would see him come home from work, and she'd say it was very frequent that he would come home very agitated due to work and often he did complain about racism in his workplace.

In Lionel Desmond's profile, how does that sort of impact his overall mental health wellness, I guess, in a home environment if he's coming home with this sort of fresh aggravation?

A. Well, it would set the ... in some ways, to my mind it would set the baseline that he then is operating from. If he's coming home from an environment where he's not felt that he's been well-treated or that he's been mistreated or has aggravated him in some sort, then he comes home to an environment where something that would be relatively trivial or minor at any other point in time becomes a source of major contention or argument between Mr. Desmond and his wife.

Q. We've asked, and it's certainly not a criticism of the professionals that have testified to date, and we asked, I believe, all of them sort of did they view Lionel Desmond in terms of, he's an African Nova Scotian; you're treating a

patient for trauma and he's African Nova Scotian, and how that comes into the mix of assessment and rehabilitation? And I'm mindful that there's a heightened awareness, moreso now. Do you think there's room to grow with a recognition that he's not only a man with trauma from the military, but he's an African Nova Scotian man, and there are those aspects and dynamics that are coming into his life stressors?

A. I think that's an important issue really. So, I mean, as an African Nova Scotian, his experience of things that happened to him is seen through the lens of his own culture, right, which may have different expectations and different sort of normative expectations of one another and families, and so on and so forth. So to the degree that it's possible to do so, to understand that, it would be a useful vehicle to sort of explore with somebody like Mr. Desmond. How does your culture traditionally deal with these issues and do you agree with this now? Do you not agree with this? Because, as you go through life, sometimes your view of your family or the normative experiences that you had growing up shifts and changes, so you can't just expect that, Yes, I deal with it in the same way that my family or my community normally does. But you may or may not agree with that, but it would certainly be an area for

exploration.

Q. Did you, in your review, ever get a sense of whether or not professionals were able to even get to the point where they're again looking under the symptoms or the immediate crisis to maybe what is causing it, which could be, as we indicated, childhood trauma but, as well, sort of racial trauma?

(12:10)

A. Not in the reviews that I saw. I mean I don't recall seeing much in the information about sort of explorations about sort of racial trauma as he experienced, because we've had some earlier discussion about ... and there may be reasons for why he chose to do it this way, but much of that information wasn't easily forthcoming from him. As Dr. Slayter noted in his report, he was somewhat vague about it. And you have to respect the person who chooses not to tell you that sort of thing but it would certainly be information that might've been valuable.

Q. Turning in terms of facts as it relates to while he's in the Canadian Armed Forces and receiving treatment from Dr. Rogers and Dr. Joshi, you talked a little bit about the success that he had with Dr. Rogers. In your review, did it appear as though his symptoms still continued to persist throughout his time while he was being treated at CAF? I guess, did they ever

go away? Did he ever reach sort of full stability? I'll use that word.

A. I don't think so. I mean, in my review, I mean he had finished his work with Dr. Rogers in the sense that she had completed the prolonged exposure component of his treatment but, in my review of the notes from Dr. Joshi, he seemed to have periods of time where, for months, he might do better, and then there would be periods of time where he would present as being more stressed or feeling more depressed or those sorts of things. So it seemed to be a course that was, as I put it, up and down over time. So whether due to the innate processes of the illness itself or whether that was due to that plus a combination of external stressors is often hard to tease out, but that would be part of what one would do.

Q. I guess my question was going to be what do you make of that because there's no question Dr. Joshi was highly qualified, highly skilled, Dr. Rogers as well, and you're still seeing the up and down with Lionel Desmond, you're still seeing the instability, I would say. What do you make of that? Do you have any sort of views as to why that was so persistent even while he was being treated in Canadian Armed Forces?

A. Unfortunately, we know that PTSD can become a chronic

condition, and once it's a chronic condition, it can be very difficult to treat. The other issue that I've noted is that Mr. Desmond is deployed in 2007, but he doesn't really come to any sort of formal psychiatric or psychological attention until 2011, which was some four years later, so developing symptoms over that period of time allows, in many ways, the chronicity of symptoms to set in. It allows sort of the cognitive errors and misperceptions that people have to sort of become more reinforced, more sustained, so that it becomes more difficult to treat over time.

Q. If you're a healthcare ... we'll use an example, if you're a psychiatrist in Nova Scotia, and whether you operate a clinic or whether you work in ER, and someone such as Lionel Desmond presents in a period of crisis, how valuable is the information to know that going as far back through work professionals and there's this persistent up and down, I guess I'll use, volatility to the symptoms. How important is that information for the psychiatrist that's outside of the immediate knowledge?

A. I'm sorry, could you just ... are you thinking of a particular context?

Q. I guess, for example, if you're Dr. Slayter and you

get a referral, that is Lionel Desmond from a family practitioner or a doctor that operates in a clinic, and you're meeting him for the first time and you plan, like Dr. Slayter did, to meet with him several times and really get a handle on who is Lionel Desmond and what's the extent of his history, is it important to know that there's a documented history of the chronicity of his symptoms?

A. Well, it would be very useful and important to know because it will help you with sort of thinking through how you would want to approach the treatment planning for the individual. So it's very different if you have somebody who is acutely ill, who's never had an illness before and the approaches that you might take might be quite different from somebody with a chronic illness where you would expect that there might be continuing sort of oscillations and symptoms over time; you might need to apply a more protracted course of therapy; pharmacologically, you might need to try different things - those sorts of things. So it's very helpful in treatment planning for the individual to know the extent and duration of their symptomatology.

Q. And did you formulate any sort of impressions or understanding of how the relationship was between Lionel Desmond

and Shanna Desmond during the period of time which was 2011/2015 while he's being treated with Canadian Armed Forces?

A. To the extent that I can draw conclusions from it, it seemed that there was some discussion about his relationship with his wife over that period of time, but much of the work seemed to be more focused on the core traumatic experiences that he had, as well as, as he approached his leaving the military, sort of concerns about how to transition to civilian life, what kind of supports he would have, where he would live, what he would do, you know, those sorts of things. And it's really in that later timeframe that issues of concern related to his relationship with his wife become more pronounced in the clinical record that I saw.

Q. And you indicated that they become more pronounced and sort of his reported complaints and, I guess, stressors, would you say, seemed to take on, more predominantly, a focus on his relationship and the frustrations there as opposed to a traumatic experience reporting in the military? Would you say that one sort of started to rise up above the other?

A. Well, in the sense of ... certainly, it's documented more frequently in the notes of the therapists and individuals that saw him, so it became more of a focus of a concern for him.

And so that related to issues related to ... early on examples were, you know, related to financial issues and stuff like that and ...

Q. As a forensic ...

A. ... issues of separation and then later on sort of increased concerns about the fidelity of his partner which became quite prominent towards the end of things.

Q. And we're going to get into those details, but as a forensic psychiatrist, is that meaningful to you in any way in that his symptomology, or the source of his complaints to professionals, seems to take on a little bit of a different look in that it's now more domestic-related or intimate partner-related as opposed to classic PTSD/military experience? Is it significant to you in any way?

A. To me, the significance would be that given that that had started to occur, one of the things that, for me, if I had been the treating clinician, I would want to explore with Mr. Desmond to what degree I might be able to either collaborate with, or get information from, his wife in order to better understand the picture, perhaps to sort of help him problem-solve around some of the issues. It's an area that would be important to do, but it's also an area there that, really, as a

clinician, you're largely bound by the wishes of your patient, right, in the sense that if Mr. Desmond had said, No, I don't want you talking to my wife, then I'm not able to really do that, although I would probably come back to the topic periodically and say, Gee, I think it might be worthwhile to sort of have a conversation with your wife to see if we can sort out some of these issues or that sort of thing.

Q. We're going to hear from Dr. Jaffe, and you're obviously familiar with Dr. Jaffe through this process, and get into the details of his sort of views. He talked about two very sort of distinct but, at the same time, intertwined, aspects that were Lionel Desmond. One was the classic mental health diagnosis and the symptoms as it relates to sort of classic PTSD, depression, anxiety, but he also indicated that there was the stressor that was very prominent, that was the intimate partner violence perspective, the chaos, I guess, that was his home life with Shanna Desmond and the long history. Would you sort of agree that there were those two prominent aspects to Lionel Desmond's profile?

(12:20)

A. So I think that there were those two aspects. So Mr. Desmond has PTSD, he has ongoing issues with his wife which

appear to be of long duration and seem to be worsening over time. And I don't have any specific comments about domestic violence, per se, because I'll leave that to Dr. Jaffe, but the other issue is whether there was some sort of interaction between those components.

So, inasmuch as in PTSD, anger and irritability and the hypervigilence symptoms are part and parcel of PTSD, whether that formed a third piece of the puzzle, so to speak, in terms of its interaction between sort of his pre-existing PTSD and issues that he had with his partner, whether each sort of interacted with the other in order to sort of increase the experience, the difficulties, that he was having.

Q. And, in your opinion, was that the case?

A. Well, in my clinical experience, yeah. I mean I think there would be an interplay between those two pieces that could've further inflamed the situation unfortunately.

Q. And from a sort of, I guess, treatment or rehabilitative aspect of that, how do you get a handle on those two intertwined streams that are happening at the same time?

A. It can be very difficult, of course, because, often, what can happen in therapy is that, because you're dealing with sort of the crisis at the moment, you have to sort of try to get

the individual to a place where at least that's settled enough that you can explore some of these other issues and, as we've talked about, potentially sort of look at other potential avenues to sort of address some of those concerns. So it can be a difficult task to accomplish given that issues of anger and those concerns about his partner became more prevalent over time.

Q. So that's a series of questions I'm going to have, and on page 7 of your report, you pointed to two examples where the prominence of Lionel Desmond's intimate partner stressors are sort of coming to the forefront. I guess, at page 7, paragraph 2, towards the end of paragraph 2, you indicate that, in an update, "October 28th, 2012, Dr. Joshi notes ..." So we're going back to 2012, so you're quite a bit in the early days, and you quote:

> When reviewed in late spring and early fall of 2012, he continues to have significant problems with PTSD symptoms. They have gotten worse by his wife deciding to separate from him. Cpl. Desmond continues to attend psychotherapy. His long-term prognosis is guarded in light of poor

response to treatment until October 2012.

So I'm going to ask you to hold that. And then two paragraphs down, again, Dr. Joshi, several years later, in April 16th, 2015, it reads:

> Not doing very well. Stressed about upcoming medical release. Planning to put house on sale. His wife is not very communicative about her intentions to stay with him or separate. Financial concerns +.

And then it says:

> No SI/HI. (suicidal ideation/homicidal ideation)

So we know, I guess, as far back as 2012 through 2015, with the military, there's the prominence of the stressor that's Shanna Desmond in that relationship. In your opinion, do you see a continuation of that when Lionel Desmond interacts with Dr. Murgatroyd and throughout the final two years of his life?

A. It's a theme that never really goes away. It's a continuing theme throughout the rest of the course of Mr. Desmond's life, unfortunately. So he transitions from the military to the civilian world. He sees Dr. Murgatroyd. Much of those conversations are often about sort of difficulties that

he's having with his partner. When he goes to Ste. Anne's, there's documentation there about sort of ongoing difficulties that he's having with his partner to the point, unfortunately, where that means that he ends up leaving Ste. Anne's without any sort of clear plan of where he's going to go because that's part and parcel of the difficulty is that it's not clear that he's welcome there, so to speak. And, of course, as we know, when he sees others, after he arrives back in Nova Scotia like Dr. Slayter, it's a continuing theme there and, as you can see throughout parts of the report, it becomes quite collaborated at times. So nightmares about sort of seeing his wife with another partner and violence and those sorts of issues. So it becomes a predominant threat of the marriage through that period of time.

Q. In terms of a global view of all the sort of documented healthcare professional records ... would it be a fair comment to say at least equally consistent is his reported difficulties with his wife as it relates in comparison to reported difficulties with PTSD and just general depression?

A. Certainly, he ends up, in his conversations with others, at least as it's documented, it seems to share equal weight. I mean he has ongoing PTSD symptoms and we'll talk about sort of the continuing sort of thoughts about sort of

people that were killed (in theatre?) when he was there, and that sort of thing, but that's almost immediately followed by conversations about his concerns about suspected infidelity of his partner and those sorts of issues, and it comes together as sort of a whole package in the sense that it's a continuing source of the reason why his symptoms remain as pronounced as they are, it seems.

Q. As a forensic psychiatrist, you indicated that one of the things you're interested in is evaluating risk.

A. Yes.

Q. And risk and you're familiar with it in the context of a criminal law perspective and that you evaluate risk of offence.

A. That's correct.

Q. This extent to which it's a minimum 50/50 share between classic symptoms of mental health and concerns in a domestic violence realm, how important is this information to have for someone like Dr. Rahman that unfortunately finds himself in a position where Lionel Desmond appears in a state of crisis and he's trying to articulate why he's there? Is that sense important to someone like an ER physician in Nova Scotia?

A. It's an important construct, although I think I should

probably sort of expand a little bit. So when I think about risk, we can think about risk in all sorts of different ways but sort of, so, in general, risk is simply the likelihood that an expected event will actually come to pass. That's our concern. And when we're thinking about risk - so, for example, we're thinking about suicide risk, you can think about acute suicide risk and chronic suicide risk. And the approaches to the risk in those situations is somewhat different. So, for example, in the Emergency Department at the QE where I work we will often see people who have a chronic suicide risk. So the common examples are individuals with particular types of personality disorders, so borderline personality disorder, (inaudible) that way. So those are individuals that often have long-term sort of ideas about suicide and they present with sort of increased risk when they're in crisis for some reason or another, right? And when that immediate crisis subsides, for whatever reason, then the chronic risk remains, but the acute risk is diminished so, in most cases, that leads to conclusions, for example, with our borderline patient population, that we don't normally bring patients with borderline personality disorder into hospital, even under situations where they say that they may be suicidal, because we know ... or if we do, we only do it for a very brief

period of time because we know that once the immediate crisis has passed, your chronic risk remains, and, unfortunately, the risk of death by suicide is on the order of ten percent for patients with borderline personality disorder, but that from an acute treatment perspective, there's not much we can do and so we tend to sort of try to move them back into the outpatient setting so that the longer term work of sort of managing the long-term risk can be undertaken.

(12:30)

Q. So I guess that leads to sort of this. So the closer you get, I guess, in time for ... in Lionel Desmond's case, to, I guess, the ultimate event, does it get harder to evaluate risk and is risk analysis something that really starts early on in the client? So in Lionel Desmond's case, an evaluation of risk perhaps starts in 2012 and not January 1st or January 2nd of 2017?

A. Yeah, that's a good point. The way I think about it is that it's important to draw a distinction between risk prediction and risk management or risk prevention, right.

So, for example, and I mentioned this in the body of my report so I'm guessing you might get to that at some point that it's very difficult to predict suicide because the rate of

suicide, as tragic an event as it is, is quite low, it's about 11 per 100,000 per population per year so ...

But we do suicide risk assessments because we're actually more ... because we can't really actually predict whether any individual at a point in time will commit suicide. But what we're interested in is ... and the reason why we really do the suicide risk assessment instruments that we have available to us is it helps inform a risk management plan so ... and in that sense you're correct.

So for someone like Mr. Desmond given that he had chronic ideas of self-harm that had dated back for some period of time it would have been in his interest and the interests of the people that would be impacted by suicide, for example, to have that information available so that you could sort of have a better informed suicide risk assessment plan for the individuals. Sort of a, for want of a better word, sort of a safety net that they could utilize when they go through periods of acute crises where that risk might be elevated.

Q. So is there some value in, I guess, an educational component coupled with maybe a practical approach to - from a clinical standpoint - putting in a structure that is evaluating risk of violence or risk of harm to others from the very first

time onward as opposed to just sort of generally treating the underlying diagnosis?

A. We have tried to do that within the Health Authority in the sense that at time of intake for an individual that they're having their first assessment, it's ... one of our standard procedures is that we do the suicide, the SRAI as we call it, the suicide risk assessment instrument, which you may have seen a copy of.

So that's an attempt to on the one hand sort of quantify risk in a relative sense, you know, and we use broad categories of low, medium, high, but more importantly it performs ... it acts as sort of the founding document so to speak of sort of developing a risk management plan.

So I mean for some people you don't need a risk management plan because their risk for suicide is low, they're not suicidal, they don't have a disorder where that's going to be an issue, but others it becomes a more involved process because it's an issue that is a chronic one and so it needs to be addressed. Not because, you know, you could be confident that by doing it all that the person ultimately won't end their own life, but simply that you're trying to sort of, in the broadest sense of the word, just trying to move them from sort of a high-

risk category to a moderate risk category, from a moderate to low-risk category, sort of just in terms of managing the risk on an ongoing basis.

Q. If I take it to Nova Scotia and I take it to Dr. Slayter, how does Dr. Slayter ever assess risk for violence, risk for homicide, come up with a protocol ... I can't remember the term you used about a risk prevention sort of protocol for Lionel Desmond, when he doesn't know what Lionel Desmond told any of the Armed Forces' specialists; he doesn't know what he told OSI New Brunswick specialist; he doesn't know what he told the professionals in Quebec, Ste. Anne's; he doesn't know what he's told family practitioners throughout Nova Scotia? How does Dr. Slayter do that? Is he at a disadvantage, I guess.

A. He would be at a disadvantage. I mean the standard for all of our staff would be that you would inquire about both suicidal ideation/homicidal ideation, which is why you see those little phrases, you know, SI/HI. And to a large extent in the absence of that information base you're relying on the response of the individual, right, and there may be various reasons why that individual respond honestly to you or there may be reasons why that individual will not respond honestly to you so ...

But ultimately the suicide risk assessment instrument is

sort of an adjunct to clinical judgment so you would do that ... use that instrument, for example. But then ultimately you try to factor in all the information that you've got available to make a final decision about frankly, you know, in an emergency room setting whether this person is safe to go home or not, right, you know, so ... And traditionally we focus primarily on suicidal ideation rather than homicidal, you know, threat for violence for others which is whole other kettle of fish in terms of risk management but ...

Q. So ideally when that process sort of began in Lionel Desmond's case, the moment he leaves the military someone is sort of alerted to those aspects of domestic violence and intimate partner risk factors and somebody begins to work on a comprehensive safety plan and structure with Lionel Desmond. Is that sort of the ideal scenario rather than have Dr. Slayter in a few months prior to the ultimate events trying to figure out from the start, I guess.

A. There's two pieces to that in my mind. One would be that that level of information would be very useful and help sort of creating that kind of plan and the other would be to the extent that it's possible to do so that ... and you'll see a lot in the literature these days, we talk about warm handovers,

blah, blah, blah, you know, that kind of thing so ... Meaning that as you transfer an individual from one service point to another service point that there are attempts made to sort of make sure that the relative teams that have been involved with the case and turning over the individual have the opportunity to interact in a way that you can have these kind of discussions, you can have these sort of key points, pass it on, so that it's known to the person who might be receiving the case that this is an area they should pay attention to, right, so ...

Q. And we'll probably hear some evidence through maybe some questions about, you know, there were actual boundaries where Lionel Desmond is between provinces and moving about. But in your overall assessment did you see perhaps a value in that sort of warm handoff or warm transfer that could have perhaps taken place and whether or not it would have been beneficial to Lionel Desmond?

A. Well, I think it would have been very beneficial because it would have ... as I've said, I think ... you know, given the information that was available at the time that that sort of warm transfer process would have allowed sort of the incoming clinicians that would be taking on the case to be more fully informed about what some of the issues they might be

expected to deal with would be as opposed to sort of just having to, in the moment of the crisis, deal with the crisis without having sort of the contextual background that informs your decisions.

Q. Okay. If we turn to page 8 of your report, the third paragraph down, the one that starts with: "Mr. Desmond saw a psychiatrist ..."

A. Yes.

Q. I'm just going to read a quote to you there, much like we did about the domestic violence-related issues in his time with the military. This is Dr. Njoku who is with the New Brunswick OSI Clinic, and you flagged this in your report, and it reads:

> My impression was that he was still very severely suffering from his PTSD symptoms, which don't really seem to have relieved much or perhaps have further exacerbated following release. He did make homicidal threats but it appears from his previous notes this on and off has been a feature with him without any evidence he'd ever act on it.

I guess to you, as a forensic psychiatrist, what do you make of that sort of passage? So we're now post-military and we're now into a New Brunswick OSI setting and we're still seeing what's described as symptoms not really being relieved and the consistent theme of homicidal threats. From a forensic psychiatrist perspective, is that of any significance to you and if so, why?

(12:40)

A. There's two elements to it there that I think that would come to mind. One is that in that he's saying that the symptoms seem to have been exacerbated since his leaving the services that this notion that we were just talking about about a warm handover either didn't occur or if it did occur it was in a rudimentary kind of way because it would suggest that the transfer didn't occur in a way that maintained what stability that Mr. Desmond may have had at that period of time. So that's one.

The homicidal ideas and I'm very glad to see that he wrote "without any evidence that he'd never acted on it", I'd be very concerned if he had acted on it but ... But again in the sense that the homicidal ideas that would be an idea for future exploration.

I know, for example, that one of the issues that Mr. Desmond had was he didn't like to be in Halifax because he found it distressing, for example, to be around people of Middle Eastern heritage, given his experiences.

So whether those homicidal ideas were related to his trauma in that sense or whether they were related to the developing concerns that he had about the fidelity of his wife would be an area of potential exploration to have. And you would, as part of a risk management plan in that, you would want to explore that with the individual and look at some of the key determinants that might sort of bring that whole thing into play.

So putting together, for example, a plan of where do I go, what do I do, who do I call if I suddenly feel overwhelmed by these thoughts. There's a lot of literature on sort of the idea that you want to remove any opportunity. So, you know, as we've come to learn, Do you have weapons around the house? Do you have things that you could use to engage in these sorts of things? Would it be wise, perhaps, if you gave those up, that sort of thing, which can be, I would expect, a tricky issue in both an individual who's a veteran and in my experience with individuals that come from rural parts of our province where gun

ownership is pretty much a norm a lot of the time. So inasmuch as that gives a person a sense of sort of this is who I am, sort of thing, but it's still a conversation that you would need to have.

Q. In your review of the records of various entities, did you see much of the way of documented discussion or, in fact, any sort of suggestion of a risk management plan?

A. Not in the sense that I've described it as sort of a robust plan with all of those elements and sort of actual contact numbers, for example. I will call Bobby at such and such and such and, you know, or go by Fred's house or, you know, those sorts of things so ...

Q. We've heard evidence that he was provided through CAF, Veterans Affairs, with a number, a crisis line that he could call in the event that he needed it. So when you talk about a risk management plan, are you talking about something more than that, of a number to call?

A. Well, when I think about it I would think about, you know, the standard things, like this is the crisis line, you can call the crisis line. In Halifax we have our mobile crisis service so you can call our mobile crisis service. But you could expand that and say, you know, Of your family members who

is it that you feel that you have the best relationship with that you could talk to, right? You know, of your buddies, who could you talk to? What things could you ... if you're feeling overwhelmed by thoughts are there activities that you could do to get your mind off it, those sorts of things. So sort of a plan that involves sort of both the formal potential contacts that a person could have to deal with a mental health crisis as well as sort of the more informal, but potentially as important, contacts.

Q. So does this involve sort of the client having a sort of list or a structured sort of protocol that they've worked on with the healthcare professional?

A. Well, the best example that I can describe is so far patients at the Forensic Hospital when they leave we put together a discharge binder that has sort of a risk management protocol for them. So that the binder includes sort of a description for the person of these are how I feel as my symptoms become worse, right, so the person can sort of self-monitor some of their symptomatology. And so when I reach this point in my symptom profile these are the people that I would attempt to contact or call and sort of connect with. And as it goes up these are the different mechanisms I could do right up

until sort of I just get out and go to the Emergency Department or something like that, right. You know, so sort of a more robust sort of documented plan so that the person could sort of even, for example, have it sort of as a card that they carry. And say, Okay, this is the number I call if I ...

Q. And is this something that's reviewed with the client between the client and professional or is it just something of, Here, I've put this package of materials together for you, you should take it? Does the clinician, I guess, or professional take the time and kind of go through all of this and how it's meaningful with the client?

A. Again, speaking to our forensic system, yes, our staff would sit down with the client and say, you know, This is what we've identified as your symptoms. Would you agree, yes/no? How can we sort of better sort of document how you feel under these certain circumstances, that sort of thing. Who do you think the best person to reach out to be would be under these circumstances? So it's a more of a collaborative kind of process.

Q. Did you see any sort of suggestion of whether or not healthcare professionals even had an opportunity to get to that point with Lionel Desmond? Sort of sit down, collaborate on a

detailed safety plan knowing the aspects of the intimate partner risk?

A. The greatest opportunity it would seem to me would have occurred when he was at Ste. Anne's Hospital when he was there for six/eight weeks, I can't remember, that would have provided some time to sort of explore some of those issues. Unfortunately, of course, when he leaves Ste. Anne's Hospital the documentation is slow to follow, you know. There's a case conference but not what I would really call a warm handoff. There's a case conference with Dr. Murgatroyd, of course, who can only remain involved in the case for a very limited period of time so ...

Q. And what do you think the warm handoff perhaps in looking ... the benefit of looking at hindsight, what do you think that could have happened? What kind of warm handoff would you envision ideally, I guess?

A. I think one of the struggles that Mr. Desmond had was that towards the end of that stay at Ste. Anne's he still wasn't sure about where he was going to live or where he was going to get follow-up services. So, for example, if he had decided that he wanted to be followed by the OSI Clinic in Dartmouth then a warm handoff would have included a case conference with staff

from that clinic as well as staff from Ste. Anne's and then preferably, staff from the OSI Clinic in Fredericton all getting their heads together sort of putting together a general transfer of care summary and some discussion about the key issues so that when he connected with the OSI Clinic in Halifax that that material is already available for him.

Conversely, if he transferred it to Nova Scotia Health, then a case conference between the same parties again but in this case involving Nova Scotia Health. That's potentially trickier to do because our systems are that ... we have referral systems, of course, and it's sometimes logistically those things are difficult to organize, particularly in an individual where you're not sure whether, you know, at the point of his departure he's going to be in Nova Scotia or he's going to be back in New Brunswick.

Q. Did you get ... and mindful Lionel Desmond left two weeks early, did you get the sense from reviewing the file that Lionel Desmond would have been sort of on the understanding of what his transfer of care was going to look like after he left Ste. Anne's in August? Was there indications that he seemed to be in the know as to what was going to happen with him, who he was going to see?

(12:50)

A. I don't get any sense that he was in the know about who he was going to see. I don't think he even knew where exactly he was going to live so ...

Q. And ...

A. Just in contrasting it to sort of our general inpatient psychiatric services, for example. So when somebody is an inpatient at the hospital and they're discharged and they've been there for anything other than sort of a brief crisis perhaps, we would normally have the appointments set up for that person post-discharge so that they know where they're going to go and on what date. So that didn't happen with Mr. Desmond.

Q. We do know that he did have ... Veterans Affairs Canada did arrange on the day of his release or the following day they had set up an appointment in New Brunswick to see Dr. Murgatroyd and he indicated, I'm returning home to Nova Scotia; that's why I'm leaving early was to see my daughter. And then there's no sort of evidence of any sort of scheduled follow-up appointment.

What do you sort of make of that situation where you have Lionel Desmond who is leaving Ste. Anne's not fully stabilized

as Dr. Ouellette had indicated, and that is the plan. They had set up an appointment for him in New Brunswick but he opts out of it because he wants to return home. Do you have sort of any views on that? So it becomes kind of problematic that he has a place to kind of go first, they say re-touch with Dr. Murgatroyd but he declines. In Lionel Desmond's circumstances, do you have any sort of suggestions as to solutions or what ...

A. Well, discharge planning is a constant issue within sort of the work that we do so ... And we have a saying or, rather, I have a saying that, Discharge begins at admission. I don't mean that in the sense that you're anxious to get the person out the door or anything like that, but simply that given that an individual is in the hospital generally for a relatively short period of time, that it behooves you to start thinking about the discharge plan at the beginning of the admission, you know. Sort of saying, Well, what are the barriers to a successful discharge; what are the challenges that the person could expect; how do I address those; who do I contact; how do I sort of get things organized for the person so that, frankly, things don't fall apart at the last second when they leave.

Q. And in Lionel Desmond's case, is that sort of ... is his profile such that you maybe ought to turn your mind to on

the horizon he's returning to Nova Scotia leaving a residential program and a need for immediate sort of organization of resources the moment he leaves?

A. I mean ideally in the time that he was there, if you were going to do sort of robust discharge planning you would have ... you know, I would have liked to have seen, you know, work done with Mr. Desmond very early on sort of, so that you had a knowledge of a confirmed place that he was going to go on where he left. And then based on that sort of ... and Mr. Desmond would have had to make his own decision in this regard, whether he wanted to be followed up through the OSI clinic or whether he wanted a local follow-up in his home community and then start that process so that, again, when he leaves he would have had a follow-up appointment at time of discharge.

Q. I guess just before perhaps we move to a lunch break, you noted at page I believe it's 8 of your report that Dr. Murgatroyd, even as early as 2015 and through the spring of 2016 before Lionel Desmond goes to Ste. Anne's that Lionel Desmond demonstrated a number of themes. I'm trying to find exactly where that is.

A. The bottom of page 8, I think.

Q. The bottom of page 8. I wonder if you could indicate,

what were some of those themes that were identified by Dr. Murgatroyd.

A. Well, as I've got listed there, so Mr. Desmond's alcohol and marijuana use, some of his ongoing symptoms of PTSD which was a major feature, irritability and anger which as I mentioned was, in part, due to his PTSD and may have been a part due to some of the difficulties he was having in his relationship at the time, which is the next issue on that list, and then these periodic ideas of homicide or suicidal ideation that would come and go over time.

Q. You noted ... as well, you noted housing instability, periodically moving back and forth between New Brunswick and Nova Scotia; continued conflicts with wife and a lack of social support and isolation. So those, coupled with the ones you identified and set out in your report as identified by Dr. Murgatroyd, when he leaves Ste. Anne's was there any improvement, in your opinion, of a relief as it relates to housing instability, continued conflicts with his wife, lack of social support and isolation?

A. No, I don't think there were. I mean, when he leaves Ste. Anne's the discharge summary, which eventually arrives, but I think came in a little bit later, the notes are ... in my view

they're sort of ... they kind of put a brave face on what he was like when he was there because they speak to sort of fairly limited success in some of the issues that he was dealing with, like the irritability and the anger and that sort of stuff, the ongoing conflict with his partner so ...

And it's not that I would necessarily think that they would have been successfully treated during that stay but rather that it would become then more important to say, Okay, well, these are ongoing issues for him so how do we sort of give him the best chance once he's gone to sort of deal with those issues. So that would mean sort of some of the things we've discussed about sort of case conferencing and warm handovers and that sort of thing.

Q. So when ...

A. Of course that's difficult to do in the context of the housing instability as well because most organizations, and ours is no different is, you know, our processes are based on your location, right. So in our Mental Health and Addictions program you can get services anywhere in the province that you want but normally we would recommend that you go to the service area that's closest to where you reside although that's not necessary that you have to.

Q. Was it important for Lionel Desmond when he left Ste. Anne's to have sort of on the ground running some sort of mechanism or model that was immediately in place that dealt with the housing instability, the continued conflict at home with his wife, and the lack of socialization ... social isolation?

In addition to his clinical PTSD treatment, would it have been beneficial for him to have a system right away when he left Ste. Anne's that there's someone in place that's going to coordinate this or a group of people?

A. It certainly would have been in his interest. I mean the issue would be that the only way that I know of to do that is ... and again, I'm just drawing on my forensic experience, so we have a position of a case manager, what we call an FCC, friends of case coordinator, so their job is to try to assist the person with those kind of issues.

So, you know, a person leaving from hospital they don't have a place to stay, well, the likelihood I'm going to be successful goes down, so the case coordinator sort of helps the person find a sort of a place where they might be able to reside, for example. So that would be might be one way to do deal with the housing issue, right, you know.

Social isolation is a tricky one because he didn't have a

network of people that he could easily go to that I'm aware of so ... But certainly you could set up sort of some of those emergency contacts to fall back on for issues.

Q. Do you think these two aspects ... are you able to comment, I guess, whether these two aspects had any effect or impact on Lionel Desmond? And I'm talking when he leaves Ste. Anne's in August, and the fact that he, I guess perhaps in many ways it wasn't clear what his structure was going to look like when he went back to the community in terms of his supports, his physicians and psychiatrists, beyond that scheduled appointment with Dr. Murgatroyd which we knew he wasn't going to continue.

What sort of impact would that have perhaps on Lionel Desmond, knowing his profile, coupled with a lack of those supports immediately when he returns to the community? Would they have any impact in your opinion on Lionel Desmond and did they?

A. Well, I think that it would be fair to say that in the absence of all those elements being addressed prior to his discharge and at least to the degree possible some of those things set into place that that would increase the probability that Mr. Desmond would be unsuccessful in reintegrating into his community.

To the extent that it transpired in the way that it did, I don't know that that could be predicted from that, but just in general that the likelihood of a successful sort of return to community with sort of stabilization of systems, which, as we've discussed, weren't really, frankly, all that stable when he left Ste. Anne's would have been worsened.

(13:00)

Q. You refer to him having an up and down course. When he left Ste. Anne's, in your opinion, where was he at? Was he at an up course or was he at a down course?

A. Well, I mean, it's easier to think about that retrospectively, of course, given the events that then later transpired, but I don't think that the goal of Ste. Anne's which was some stabilization was successful at the time that he was there, so in that sense and given that a lot of those discharge planning pieces were sort of left hanging, that would sort of suggest a downward trajectory for him.

Q. And you talked about sort of a setback, I guess, in rehabilitation. You referred to that earlier. Did you see any signs that there was a setback in perhaps Lionel Desmond's rehabilitation after he left Ste. Anne's?

A. Well, after he leaves Ste. Anne's he's faced with a

number of sort of new challenges that he'd had very little preparation for. So he moves home to Nova Scotia and that's distinctly different from sort of the history where he would go back and forth over the course of many years that he did.

The services weren't lined up and so he's transitioning back to a home community and I don't know whether that was a source of comfort for him or whether that was a source of aggravation, right. So, I mean, that would be sort of another issue that goes into the mix of the things but, in short, I mean, he moves to a home environment where a lot of the conditions for success aren't available to him.

MR. RUSSELL: I guess at this point, Your Honour, it's sort of a natural stopping point.

THE COURT: Thank you. All right, thank you, Counsel.

We'll take a break. It's 1 o'clock so we'll take a break for an hour for lunch and come back at 2 o'clock then, please. Thank you.

COURT RECESSED (13:00 hrs.)

COURT RESUMED (14:04 HRS)

THE COURT: Thank you. Mr. Russell?

MR. RUSSELL: Thank you, Your Honour.

So, Dr. Theriault, we're going to move into another aspect

which would be page nine of your report. Just to sort of orientate you, it's going to be sort of a series of questions and topic revolving around sort of domestic violence flags, I guess, coupled with this concept of delusion and paranoid thought. Just to orientate you to page nine of the report and at the second paragraph, you noted, I'll just read it in:

> Much of the documentation, both from in person meetings as well as phone calls, focuses on Mr. Desmond's increasing sense of distress concerning the motivations of his wife, and an increasingly pervasive sense of paranoia.

And then you list two examples on that page, the first example you use is July 3rd. This is Dr. Murgatroyd's note where he notes: "Intrusive thoughts, disturbed sleep (including night sweats), paranoia, and homicidal thoughts (without intent) all occurring on a daily basis." And then if we look down to the second-last paragraph on that page, again you cite Dr. Murgatroyd's note that reads:

> He said he had been having nightmares lately where he catches his partner cheating on him. He states that some of the details are

gruesome, for example, finding the man's head on the floor. He is wondering if there is meaning behind the dreams and whether his wife might be cheating on him. He said his wife laughed at him when he asked her about it rather than giving him a straight answer.

And then further, the last source you reference, again Dr. Murgatroyd:

He indicated that since his partner's parents have returned to Antigonish things have deteriorated in the household. According to him, the partner has been sharing sensitive/ personal information about Mr. Desmond to her mom. This really upset Mr. Desmond and he feels he cannot trust his partner. He also indicates that she has been 'holding on' to divorce papers, which is also upsetting him. He feels that she is being manipulative and is unwilling to work on the relationship.

You're familiar with those records of Dr. Murgatroyd.

A. Yes.

Q. So my series of questions are going to start with your opinion as it relates to that first paragraph where you said "an increasingly pervasive sense of paranoia". So I'm wondering, Doctor, when do you start seeing that increasingly sense of paranoia and what level of pervasiveness is it?

A. My recollection from the file is that it was always a theme to some extent. But towards the end of his time in the services, it became a more pronounced ... he'd gone through a period of time where the main focus was on the trauma. And then he had a period of time where he was dealing, at the same time, with a number of work-related issues which was while he was still in active service. And then as he transitions out into the OSI Clinic in Fredericton, he becomes more focused on some of these other issues and they're related to the concerns about financial issues with his wife, but increasingly become more preoccupied on issues related to proceed or concerns about infidelity on the part of his wife. So, in that sense, they became more pervasive because it becomes more of a persistent theme of the conversation.

Q. And from a forensic psychiatrist perspective, is this concerning in any way when you're looking forward and trying to evaluate risk of future violence or harm to himself or others?

A. Well, it would certainly be a flag that would need to be explored. It's an issue that, as Dr. Slayter says later, that, you know, Is this of a delusional proportion or not, which would be a particular red flag. But even prior to that, an increased preoccupation with that would suggest that Mr. Desmond becomes ... increasingly difficult for him to sort of tease out his concerns in a realistic kind of way.

Because I think, if I recall, one of the notations in the chart that ... he holds onto that perception, although he can, at points, accept that that might not be true. So that separates it out from a delusional idea. But, still, it's a preoccupation that he has, so ... and that would be a concern from a perspective of a domestic violence situation.

Q. Did you ever get any sense that this preoccupation which seemed to be fairly steady throughout 2015/2016, did it appear to you as though healthcare providers were ever able to get a handle on that?

A. I don't see any information that suggests that they were able to get a handle on it in the sense that it diminished over that period of time. I mean it seemed to be an issue that would come up periodically in conversation in which the general approach seemed to be general problem solving with Mr. Desmond

and trying to get him to sort of discuss whether ... you know, how dearly he held that view or what other possible explanations there were for it. But it wasn't an issue that dealt with it in the sense that it was broadly discussed or sort of settled in some fashion.

(14:10)

Q. What sort of level or extent of a role do you think his persistent, I guess, chronic beliefs as it relates to Shanna Desmond, her infidelity ... the idea of her infidelity, the finances, taking advantage of him, the pervasiveness, what sort of level do you think that played in his overall psychological profile and his struggles in 2016 in the months, I guess, leading up to the tragedy?

A. My sense would be that they interacted in the sense that the financial concerns were of a longstanding nature, but they lent themselves to sort of concerns about other venues, so the domestic issues related to infidelity. And those act in concert to increase his preexisting level of irritability which was a feature of his PTSD. So they acted in concert in a cycular kind of fashion to each increase the other in some ways.

Q. And the particular line that says "paranoid and homicidal thoughts (without intent), all occurring on a daily

basis" ... so it's described on a "daily basis" of homicidal thoughts without intent. Is this something that's concerning from a forensic psychiatry perspective, that if you have a client or patient that's expressing homicidal thoughts on a frequency of a daily basis?

A. I think it would be concerning, of course, to any psychiatrist or mental health professional. So I think it would normally lead to some discussion about ... we've talked a little bit about safety planning, but sort of a safety plan to address that issue. So, you know, if you ... what would you do, or, how could you deal with issues should they reach a point where you are worried that you might actually act on some of these thoughts?

Q. And so I guess my question is we see a pattern where Lionel Desmond is articulating homicidal thoughts in some great detail about violence towards his wife and idea of a partner, so much so that he even indicates that, Well, perhaps there's meaning behind the dreams. And then he says to Dr. Murgatroyd that he wonders if there's meaning behind the dreams and he says then when he speaks to her about it, she laughs at him. So I guess my question is, and it's hard because he's not sitting across from you, but is there any sense that perhaps these

dreams that he's disclosing are sort of thoughts that he's having of homicide towards Shanna Desmond and others?

A. I think they could certainly be interpreted that way, that it's ... I mean there's ... I'm not a particularly big fan of dream analysis, but you could see a dream like that as sort of being a wish fulfilment in the sense of a person who feels that they've been slighted to the degree that it's an unforgivable action on the other person's part.

Q. I guess ... yeah. I guess in the context he's describing sort of a horrific sort of scenario. But then he's sitting in front of a professional saying, Oh, is there meaning behind it? He's thinking about it. And then he even goes as far as to then say he can't trust her. So is there aspects in that, is it possible, in your view, or are you able to comment whether or not these were actual thoughts that Desmond might have had and that he's disclosing them, I guess, in the form of just dreams?

A. That's certainly a possibility. I don't know that I could comment further whether that was thoughts that he had that either he sort of related to others his dreams or whether they were dreams that sort of, in their own way, sort of were the thought manifested in his sleep, so to speak.

Q. Is this sort of level of frequency and this level of graphic detail, is this the type of information that would be important to a professional, whether it's a therapist, a psychologist or a psychiatrist, seeing Mr. Desmond in a moment of crisis in Nova Scotia, would it be important that they have this information, that they know he had sort of frequent intrusive thoughts on a daily basis about harming his wife?

A. It certainly would be useful information. Again, it would depend, to some degree, on the context in which you see the individual. So you might be in ... the context might be sort of an immediate crisis, in which case you might be a little more focused. But just in terms of helping inform your overall opinion, it would be useful information to have.

Q. Did you see sort of perhaps, in hindsight, and sort of your global review that at times perhaps there might have been more of a focus on the classic PTSD symptoms and analysis as opposed to looking at, Well, his portrait seems to be heavily influenced by domestic stressors.

A. I mean certainly the PTSD played a large role in his presentation and it did early on. But, as we've had some discussion, that in some ways becomes more intermixed with the other issues as time goes on and, in some ways, becomes a more

predominant theme in the sense that it's increasingly focused on how he feels that financially he's been mistreated by his partner, that she can't be trusted, that there are these various reasons why that might be the case, up to and including the concerns about infidelity.

So that, in a therapeutic setting, would become, as we would say, grist for the mill in the sense that it would become a topic of discussion because the violent dreams that he has would be sort of a red flag that it's an area that you want to explore and develop as much as you can, as we've talked about, a safety plan not just for sort of suicidal ideation which he had on a chronic basis, but the potential for other potential outcomes as well.

Q. In your experience as a forensic psychiatrist, how common would you say it is for a client or patient to have, as Dr. Murgatroyd outlined, paranoid and homicidal thoughts on a daily basis? How common is that?

A. I've seen cases of a similar nature over the years where it's been a case of domestic violence, and that includes murder. But the intensity and frequency of those thoughts, just from my general recollections of those, probably wouldn't be as intense as the information that I have about Mr. Desmond in

terms of how frequent they were for him.

Q. So I guess to try to put a gauge or a handle on it, in your review, compared to all the cases essentially you can recall that you assessed, where does Desmond fall in terms of, I guess, the bell curve relating to level of intensity, level of frequency of homicidal disclosures and sort of suggestive risk factors towards his spouse?

A. He would be at the severe end of that spectrum of preoccupation with those thoughts ... those themes.

Q. And that's over the basis of your career?

A. Yeah.

Q. So I guess what ... one of the goals here is to sort of try to make sense out of is that meaningful and, if it is meaningful, why. So I guess having him on the more severe end of things ... extreme end of things about repeated disclosures in that way, is that concerning or ought to be concerning?

A. Well, it's concerning because; one, it's a potential red flag. It's part of sort of a dynamic risk assessment that you would want to take into account. And it's concerning because inasmuch as it plays into his PTSD symptomatology, the issues are co-related in that it's difficult to disentangle one from the other and they both seem to exacerbate one another.

So it would be, from a treatment planning perspective, it would be ... at some point you would probably be required to tackle both of those issues in some sort of meaningful way if you're going to find a point where you could have stabilized Mr. Desmond.

Q. And in your opinion, looking at everything ... and it's certainly not a criticism of the healthcare professionals that were seeing him in particular moments of crises. But, globally, were they ever able to sort of untangle that dynamic which was those two intertwined factors successfully?

(14:20)

A. Not to my knowledge, no. I mean, in part, it was I think because there are a number of other intervening variables that also confounded the situation, the moving between treatment providers while he was in the military and outside of the military and those sort of connections issues that created problems with transitions of care. So that created the dynamic in which it was difficult for Mr. Desmond to settle into a clinical environment where those issues could be dealt with in a more longitudinal fashion.

Q. And what do you mean by dealt with in a "longitudinal fashion"?

A. Meaning dealt with over time. So in order to deal with an individual like Mr. Desmond, in addition to some of the evidence-based practices that we've talked about, there's a need to develop sort of a continuing rapport with the person. So it's only once you had a continuing rapport with the person that you would be able to really disentangle some of those issues so that you can say, Today, I want to talk about this and tomorrow I want to talk about that and sort of have Mr. Desmond feel comfortable enough to sort of get at some of those issues in a meaningful way that you could address them.

And that's equally difficult to do in some of the other situations that occurred which his social environment was unstable and so he didn't have sort of a stable place to sort of just be on his own that would allow him to sort of process some of that information if it had been provided to him.

Q. There are several examples where ... in the materials where Lionel Desmond became agitated with treating professionals. He was described as difficult to redirect. He was described as ... ultimately by Dr. Murgatroyd who went as far as to say, Because of his instability, we're not even able to get to trauma treatment. When Lionel Desmond comes out of Ste. Anne's in August, do you have any views as to whether or

not they could have successfully ... outside of Dr. Rogers, I guess in the military, whether they could get to any sort of trauma treatment with Lionel Desmond?

A. I certainly don't think in the work that was done at Ste. Anne's that the focus was on any trauma treatment. It was really just stabilization in that broad sense of I think trying to have Mr. Desmond be less emotionally ... emotional dyscontrol, if you know what I mean. So it's sort of a less prone to sort of angry outbursts and stuff like that, which I think, as we've talked about, the had some limited success in doing.

So they didn't get to specific trauma treatment and they didn't get to specifically some of the ongoing issues that were driving some of the whole dynamic forward, the instability of the relationship and what he was going to do there and what his wife was going to do. So those were never really addressed at Ste. Anne's. And then, of course, he's back in Nova Scotia and it's a period of time before he gets connected to services thereafter.

Q. And, in your opinion, when he leaves Ste. Anne's, has he achieved stability?

A. No, I don't think that he had achieved stability, both

in the sense of ... I don't think, when you read the discharge summary, that there is a clear sense that some of the emotional dysregulation, as we would call it, has been brought under reasonable control and, in part, because a lot of those elements that are required for a successful discharge planning and transition aren't put together in sort of a package that allows him to transition to the next care provider in a smooth kind of fashion. So that continues to underline his stability.

Q. So we have him as, in your opinion, that he leaves Ste. Anne's, you indicate that stability is not there. What sort of role, are you able to comment, does that instability play in Lionel Desmond's condition and circumstances as he navigates the community between August and the events of January 3rd?

A. I tend to think of this issue both from trying to think of it from the perspective of Mr. Desmond as well as the perspective of the care providers that he had contact with. So from Mr. Desmond's perspective, my sense would be that he finds himself back in his home province but sort of without a basis of social support that he really needs in order to sort of just get himself settled in one place so that he can sort of start to think through some of the issues that he has.

He's ambivalent about where he wants to receive services. So, at one point, he's referred to the OSI Service, but ultimately decides that he would rather have the service closer to his home community. So, you know, those are ongoing destabilizing features. And then from the continuing care perspective, from the care providers, he's seen by Natasha Tofflemire, I think, was the person that did the intake assessment form at the OSI Clinic in Halifax. And they conclude with Mr. Desmond that he would prefer to be seen at the local clinic. It takes a certain amount of time to get set up in that local service provider and, in the interim, he's waiting to be seen and eventually gets seen by Dr. Slayter.

And then again, after an initial assessment by Dr. Slayter, then more definitive one, if we want to call that, on early December, but all of those are sort of just points in care rather than sort of the individual being brought into a system of care where there's a variety of people involved in the case, that's case management, a way to help him deal with some of these other issues.

Q. So you mention about points of care and systems of care and the difference. So did Lionel Desmond need more than, I guess, points of care? Did he need a system of care the

moment he left Ste. Anne's?

A. Well, that certainly would have been ideal. I mean I think with the factors that were at play when he left Ste. Anne's, in my mind, there were three main needs that he had. One was ongoing treatment for his PTSD, one was further exploration of some of the issues related to his wife and the level of paranoia that he had come to express about her. Part and parcel of that would be sort of an exploration and work with Mr. Desmond to help him with his feelings of general mistrust which seemed to be an issue in Ste. Anne's in terms of, towards the end, his sense of whether he could trust his treatment team, for example.

So that might require care providers to think about, given the dynamics that they knew about Mr. Desmond, who might be the best care provider for him. And then there are other social aspects about where was he going to live, how was he going to make ends meet, all those sorts of things.

So if you had a system of care involved with somebody like that, which of course be quite resource intensive, you could have, for example, a psychiatrist to deal with some of the medication issues around PTSD. You could have another therapist dealing with PTSD itself. You might have a social worker sort

of work with Mr. Desmond around some of the social issues and the issues he had with his partner at the time. So that would be sort of a system of care.

Q. And is early intervention of a system of care important in Lionel Desmond's case?

A. Well, in general, his was a chronic case and a complex case. So I think by the time that Mr. Desmond comes back to Nova Scotia, he's now been in therapy for a number of years and, unfortunately, my view is it turns out that much of that has been done either through ... under the umbrella of another organization or in another province. So when he comes to Nova Scotia, he's not known.

It's not like he's been in a system where he had been receiving services through Nova Scotia Health for a number of years, which would have made it much easier to make sure that the coordination pieces were all put into place. He comes in from outside with very limited information as to what's been transpiring over that course of time. So it makes it much more difficult to put a team together.

Q. Do you have any ideas on how we can maybe take someone like Lionel Desmond and move them from being unknown, as they move back into Nova Scotia, to being known? You talked about

the benefits of it, but I guess I'm interested in your thoughts on a solution. How do we make Mr. Desmond and his mountain of tangled profile a known element when he returns to Nova Scotia in terms of Nova Scotia's healthcare system?

(14:30)

A. Well, I think that inasmuch as you're able to do so, and I can't pretend to understand the whys and where nots of how different organizations process information. I had, for example, done work with CSC where getting the information from CSC is, honestly, a very painful process to get information from them. So for somebody like Mr. Desmond, if he's coming from a place where he has received the vast bulk of his therapy, and whether that therapy was successful or not, would also have the information that would inform therapy going forward that as much transparency as possible in allowing that information to flow freely from place to place would be important to ongoing care providers.

That's said though without, and I don't know to what degree this applied to Mr. Desmond, I mean there are limits about information sharing that have to do with sort of the autonomy of the individual that allow for information to be shared, but to what degree that applies in this case, I'm not entirely sure.

Q. You said you had difficulty getting information from, did you say CSC?

A. Correctional Services Canada.

Q. Okay. The question I sort of have is, I guess there's a microsystem that's in place, which is Ste. Anne's, for Lionel Desmond's world in that he has an art therapist, he has a structured routine, he has a psychiatrist, he has a routine of medications, he has certain counsellors he meets with, certain therapists. And then he's in that setting and then he leaves early in August and, essentially, other than Dr. Murgatroyd that's in place, there really isn't sort of anyone that's as part of that structured team.

Knowing Mr. Desmond's profile, are you able to comment on whether or not that sort of turning off the tap, what impact that might have on his presentation. So he goes from a world that's very structured and organized, Ste. Anne's, to one that's, I guess, quite a bit looser in that there isn't that level of intensity. Are you able to comment on any impacts that might have or had with Mr. Desmond?

A. Mr. Desmond had a number of treatment needs across a number of domains. So he had treatment needs related to his PTSD. He had treatment needs related to some of these issues

about the anger and the paranoia that he had towards his partner. He had treatment needs that were less of a medical and perhaps more of a social nature in terms of stability of housing and placement in the community and those sorts of things. So the work in Ste. Anne's was really targeted at a fairly narrow focus of some of those things to provide some stability of his emotional state in the belief, I suspect, that if they were able to do that then that would at least put him in a better place to address those other issues. My concern was, is that given that that really wasn't terribly successful that he then goes on to a new environment where that's still active and the other sort of domains are really not sort of available to be addressed in the short term at least.

Q. I guess other aspects of his surrounding circumstances, which are his wife, housing, support network in the community, are those aspects quite a bit different when he's outside of Ste. Anne's and when he is in Ste. Anne's in terms of a level of stressor perhaps?

A. Well, I suspect that they were much more immediate. Suddenly, you're gone from, theoretically, wondering how do I deal with this situation to being in the situation, which for somebody that has not reached a point where they're emotionally

stable, would be distressing to both parties involved, I would think.

Q. Do you have any thoughts on ... The facts would seem to suggest that that continued for some months after he left Ste. Anne's. He doesn't get assigned a clinical care manager until later November, as well as put in touch with a therapist for around the same time So he goes a substantial number of months without any structure. Is there any sort of comments you would have on the impact that that may have on him and his current sort of overall health wellness?

A. Well, he comes home to Nova Scotia from New Brunswick and he's dealing with these number of issues that are, as I've said, both of a therapeutic and sort of a social nature. So they're an ongoing issue for him. So that lends to continuing destabilization of his illness certainly. He is referred to Mental Health Services and he gets connected. I don't know that, unfortunately, given the timeline of how things ultimately unraveled that there was enough time really to build that sort of comprehensive team around Mr. Desmond that ultimately might have been successful in sort of mitigating at least the worst of his symptomatology issues that he had.

Q. In terms of page 13 of your report, under the heading

of Discussion, your very first line. I'm just going to wait for it to come up there. You indicate, "Clearly, Mr. Lionel Desmond was a complicated person and this was a complicated case." It's very broad, I guess, but if you could tell us what made Lionel Desmond a complicated person, in your opinion?

A. Not being trite, of course, but everybody is complicated in their own way, but Mr. Desmond was complicated because his was, you know, starting with the clinical side of things, his was not a straightforward clinical case. So, for example, in my practice, if I see somebody with acute depression, right, I might be able to sort of make recommendations to the family doctor, start an anti-depressant, and six weeks later, they're doing well, right, so that would be an uncomplicated case. Clinically, his was complicated because there's a delay in his seeking treatment. So that's one of the first issues. The treatment that he receives is, in some respects, quite good but, in other respects, there's a lot of transitions between treatment providers. So that lends to some ongoing destability.

So when he ultimately leaves the military and returns to Nova Scotia, his clinical situation is still quite active. So that's another complication. Then mix into that sort of some of

the issues that we've had further discussion about this morning, some of the questions about early traumatic experiences about which we don't know a great deal. The ongoing conflict within the family dynamic, which played out over many, many years but which was never really ultimately resolved in any satisfactory fashion. And those all worked together to sort of create a series of conditions in which his clinical care would be very difficult to manage because of the chronicity that had developed by that period of time.

Q. So would you say that, I guess, Mr. Desmond is quite a bit more than simply a military veteran diagnosed with PTSD and suffering from PTSD symptoms?

A. Yeah, he's a man, who has PTSD and suffers from PTSD symptoms, and he is a veteran, but he's an African Nova Scotian. So there are issues there that may play into it. He's in a nonsatisfactory relationship, which may play into it as well. He has a number of continuing issues with anger and increasing paranoia, which play into it. So all of that makes it less than just a straightforward case where, in contrast, for example, somebody who might have PTSD but otherwise has good social supports, their life is relatively stable, they may have a lot of symptoms of PTSD but they don't have to worry about sort of

their income or their livelihood or their partner. They don't have family tension. So none of those are true in this case. So it makes for a much more complicated picture in trying to determine why Mr. Desmond responded to stresses the way that he did and what ultimately happened.

(14:40)

Q. So I guess that's the first half of the first line about him as a complicated person. Then you indicated that this is a complicated case. You sort of touched on a number of aspects but what did you mean when you said this is a complicated case?

A. To me it's complicated in two ways, really. The first is it's complicated clinically. So as we've talked about, it was complicated because there are a number of factors apart from the PTSD in and of itself that complicated his presentation. It was complicated that way. It was complicated because there were several transitions between care providers, some of whom had relatively good success and others with less success in dealing with some of the ongoing issues.

It was complicated because of the transitions that he had and the degree to which those transitions were really a warm handover so that adequate information was provided from care

provider to care provider so that he didn't have to take two steps backwards to take one step forward, so to speak, in terms of the work that you were doing with the individual.

Q. I'm going to move into a conversation about PTSD. Certainly we've heard a great deal of evidence about what PTSD is, how it's diagnosed and the various diagnostic criteria. So I won't review those with you. I'm more interested in, I guess, your comment that PTSD involves several clusters and then you were able to point to what sort of cluster of PTSD symptoms, in your opinion, Lionel Desmond had. I wonder if you could tell us.

A. So the four clusters that we think about when we have PTSD in its current iteration, anyway, is that you have the cluster or re-experiencing symptoms. So for somebody like Mr. Desmond, that really focused on issues related to his experiences in Afghanistan, some of the things that he witnessed, some of the things that he saw while he was there and that leads to the intrusive symptoms like nightmares and intrusive flashbacks, those sorts of experiences that a person has. So that was a big component of his presentation, at least in the documentation that was available.

He also had a number of the avoidant symptoms. So I think

when he was first seen in 2011, he reported that he was having difficulties going out to stores and hadn't been to the grocery store in a while and these sorts of things so ... And those avoidant symptoms are often related to the intrusive symptoms in the sense that the person avoids going to those places because there are cues in the environment that then remind the person of the traumas that they've experienced. So classical examples are things like loud noises and that sort of stuff.

And then there are changes in cognition and mood which led to Mr. Desmond, as I wrote about a little bit in the report. He's concurrently diagnosed with major depressive disorder as well as PTSD. And so he often reports a depressed mood in a sense of hopelessness and stuff like that and that goes along with some of the chronic suicidal ideation that he had. So that's the third symptom cluster.

And then the fourth symptom cluster are the hyperarousal symptoms. So they can be something as straightforward as the person startles easy when you ... I often ask people, when the phone goes off, do you jump, right. They go, Oh, yeah, I jump, that sort of thing. But anger is considered a hyperarousal symptom, as is problems with sleep, which Mr. Desmond was treated on and off for for some period of time throughout the

course of years.

Q. And how, and there's a reason why I'm going to ask this. How prominent were the hyperarousal symptoms in Lionel Desmond's portrait?

A. In many ways, I think they parallel some of the other discussions we've had about how over time some of the concerns about his spouse came to the fore as an issue for him. So early on in the work that was done with Mr. Desmond, I mean some of the hyperarousal symptoms were related to anger but they were also related to sort of irritability at sort of things that were happening in his work environment, for example. So that came forward in some of the work that had been done with him while he was still in the military. But the hyperarousal symptoms continue on after and they become, in my view, increasingly targeted around some of the issues related to his wife. So he's concerned about infidelities, which often for individuals that I talk to with those sorts of thoughts, they're exquisitely sensitive to what they feel are indicators that the person has done something untoward. So where they've been, how long they were out, what did you do while I was out, you know, those sorts of issues. That seems to play a role in his presentation over time. And the anger becomes an ongoing issue and that's an

hyperarousal symptom as well.

Q. I was going to ask this later but it's probably proper to ask it now. You reference some information about studies that have been done where individuals with PTSD and I believe, in particular, veterans with PTSD, and a risk factor for violence and an emphasis on the hyperarousal symptoms. I wonder if you could tell us a little bit about that?

A. Yes, that was a study out of the UK. So it was looking at veterans from Afghanistan that were in the UK services and they looked at individuals who developed PTSD post-deployment and then they studied that population to see what rates of violence were post-diagnosis. They found that PTSD was and is a risk factor for violence but that, in particular, the hyperarousal symptoms seemed to be an increased marker, so to speak, for violence.

Q. In your sort of, looking at this from a risk evaluation sort of aspect retroactively, did you see anywhere along the way where the clinicians that interacted with him perhaps looked at an examination of his hyperarousal symptoms and how they might have connected to this idea of risk for violence?

A. I'm not sure that I saw that anywhere in the breakdown

of the record. So just by way of example, I mean I've seen many patients with PTSD over the years and sometimes certain symptom clusters come to the fore and other are less apparent. So it would make clinical sense, for example, that if I had somebody with PTSD whose main symptom cluster is largely in the avoidance area, that I might not be as concerned about potential risk as somebody who has got a predominantly angry affect that's ... the irritability that's part of their hyperarousal symptoms. So it would certainly be ... You would want to take any patient's presentation and think about it and say, Well, what does this tell me about sort of what are both my treatment targets for this individual as well as what are those areas of concern that I should try to focus on mitigating as soon as possible.

Q. And you have the benefit of sort of looking at this retrospectively and with the benefit of all the information gathered in one place. Are the hyperarousal symptoms to the level that you noted, ought they have perhaps serve as sort of a risk indicator that he has potential for future violence?

A. Well, they would certainly be a red flag. I mean we know that there was information available that at times when angry he would break things or sort of slam things around, I can't remember the proper term. So inasmuch as violence to

property is a risk factor for future violence to people that would be a red flag that way, yes.

Q. You talked a little bit about PTSD risk factors earlier and I guess at page 15 of your report, in the middle of the page, it says, "Not all individuals ..." I guess it's going to be right up at the top of the screen there. We often hear it's almost become a sort of buzz word. It's referenced on TV, it's referenced in conversation, I have PTSD as a result of this and PTSD as a result of that. You noted, however you said, "Not all individuals who are exposed to trauma develop PTSD; in fact, a minority do." Where is the sort of basis of that statement coming from?

A. I don't know how much of the history of all this you want me to go back into but I'm just going to have a drink of water here for a second.

(14:50)

Q. Sure. We'll bring up Exhibit 332.

EXHIBIT P-000332 - FOOTNOTE 4 - THERIAULT - RISK FACTORS

A. So to start with, just by way of a little bit of history, the criteria for the DSM, of course, changes over time. So we're now in the fifth edition. And PTSD first came into DSM-III, which came out in 1982, I think. As you might have

heard, in its original iteration, in order to be diagnosed with PTSD, you have to had experienced a traumatic event that was outside the normal experience of somebody. In other words, it was an extreme issue.

But in the current diagnostic criteria, it's much broader. So it includes events where you were exposed to or subject to violence or potential serious harm or sexual violence in a number of different ways. So that widening of the definition means that many more people technically meet the trauma criteria, what we call the Criterion "A" criteria for PTSD.

So when you look at the literature, something on the order of 50 percent of people have had a trauma that would meet the "A" criterion. But most people who experience trauma don't go on to have PTSD. They may go on to have other psychiatric conditions, like depressive episodes or anxiety episodes and adjustment disorders and that sort of thing, but PTSD is still not the norm for people exposed to trauma but there is a correlation between the severity of trauma and the likelihood of developing PTSD. So the more severe the trauma, the more likely it is that you would develop PTSD as a result. And certainly Mr. Desmond's experience of trauma was at the extreme end of the things that would be expected.

Q. And you note that there are three, I guess, risk factor domains going into PTSD.

A. Sorry, risk ...

Q. Are there three risk factor domains in terms of PTSD or developing PTSD?

A. Oh, there's, yes, so there's ... You can think about it ... It's a bit like our general conceptualization in psychiatry. So you can have predisposing factors. So for PTSD, predisposing factors, and you can break these factors down into both what we call static and dynamic risk factors, which we may have had some discussion about previously.

So static factors would be things like educational achievement, right. Or, more broadly, IQ. A family history of psychiatric illnesses, that's a predisposing factor for developing PTSD after a trauma. And then you have sort of the precipitating factors, which is usually the duration and the severity of the trauma itself. And then post-trauma factors that can be either protective or lead to worsening of the symptoms. So those are some of the things that we've talked about early. So social, cohesion of the individual's environment, their ability to have a resilient mindset, early intervention to treat symptoms, and those sorts of things. So

those are sort of the three sort of areas that we would consider.

Q. I want to focus a little bit on the ... You talked a little bit about the pre-traumatic, which was some of the experiences he had even pre-military in his personal life. You talked about, is it peri-traumatic, which is the actual ...

A. Around the time of the trauma, yes.

Q. The trauma events. But post-traumatic. And, in Lionel Desmond's case, when you're looking at sort of risk factors for PTSD and how they played a role, what were some of the post- factor aspects of Lionel Desmond's life that impacted his PTSD symptomology? Were there any and, if so, what were they?

A. To my mind, the post-factor issues were, they were both of a clinical nature as well as sort of more of a social nature. So, clinically, as we've discussed, he doesn't come to clinical attention for some four years after his trauma exposure. So that has allowed time for some of those symptoms to become relatively well embedded or well set. So that creates sort of an ongoing perpetuating factor for the continuance of his symptoms.

His return from deployment is complicated by some of the

changes in his unit that we talked about this morning and some of the conflicts that he had with peers, which to the degree that that was part and parcel of the PTSD or separate from is hard to gauge but would have still been sort of an ongoing factor to undermine his ability to sort of manage the stressors that could have led to sort of worsening of his PTSD.

And then we've had some continued discussion about a number of those social factors that he had in terms of essentially a long distance relationship with his spouse and sort of the ongoing dynamics there. So those would continue to sort of act as destabilizers to his presentation.

Q. At the bottom of page 15 of your report, you talk about early interventions and you've mentioned that a few times about the importance of early interventions and you note: "Early intervention is critical in the treatment of any psychiatric disorder, and this is true for posttraumatic stress disorder." Did you see any sort of concerns or issues and importance of early intervention as it relates to Lionel Demond specifically?

A. It's certainly an interesting area. When I was doing some reading around PTSD in military culture, I mean one of the issues that they sometimes struggle with is how do you get

somebody who may have developed PTSD to actually come forward and talk to somebody about having PTSD? The writings that I had read spoke a lot about military culture as one in which, although hopefully it's changing, in which a lot of individuals are concerned about coming forward to discuss whether they have PTSD symptoms because they worry that it might impact negatively on their career and those sorts of things. So that often will delay an individual coming forward to present.

Because in addition to the diagnosis of post-traumatic stress disorder, we have a diagnosis in the DSM of acute traumatic stress disorder. So meaning that the person develops symptoms within a very short period of time after the trauma and we know that if an individual is treated for those symptoms early on, that that can often truncate the presentation of PTSD. So it can sort of keep the person from developing full-blown PTSD after the fact.

So that combination in delay in coming forward, whether that was due to Mr. Desmond's own concerns about its potential or due to other factors would be a complicating factor that, as we've talked about, creates an environment where much of the symptomatology becomes quite set by the time he presents for presentation.

Q. And we know that there were a number of years between deployment in Afghanistan in 2007 before he's actually in a clinical setting for PTSD in 2011. Is it your opinion, for whatever reason, we don't know why that was the case, but is it your opinion that sort of early interventions or identification or a lack of, I guess, for whatever reason, impacted Lionel Desmond's chronicity of his PTSD?

A. I think if he had been identified earlier and received treatment earlier, yeah, that that would have had a positive impact on his PTSD. But the reasons as to why he didn't access services earlier, I don't really know. Again, when I was reading some of this material, there was an interesting review that looked at individuals coming back from deployment who were given screeners, like questionnaires for PTSD immediately post-deployment and they were actually pretty poor at picking up people that eventually developed PTSD. But if you waited four or six months and then redid the screens, it was better at picking it up because the argument was that people immediately returning from an operation theatre somewhere were so caught up in sort of just returning to some sort of their environment and may have a number of these concerns that they don't want to bring forward but given a passage of some time but not too much

time, that might allow them to sort of reflect on those experience and say, Gee, there's something not right and so maybe I should do something about it, right. So it's essentially finding that sweet spot. When is the best time to sort of try to intervene to get the person at their earliest opportunity.

(15:00)

Q. You noted, you referenced a study, it was Exhibit 332. At the bottom of page 15 of your report, you refer to it as the Sayed *et al* review. And in your report, I'll just read it, you said:

> Several psychosocial factors are associated with resilience following trauma to decrease the chance of developing psychopathology such as depression, substance abuse and PTSD. These factors include optimism, cognitive flexibility, active coping skills, the extent of one's social support network, physical health, and embracing a moral compass.

And that was I believe ... and footnoted which we have marked as Exhibit 332 of that study. I wonder, Doctor, if you

could sort of explain that to us in the context that was Lionel Desmond.

A. Some of those factors as I look at them are internal to the person and some degree are external to the person, so those that are internal to the individual are a sense of optimism about the future, cognitive flexibility, active coping skills for example.

It's a difficult area because in some ways, as we had the discussion this morning, pre-deployment there didn't seem to be any indicators that Mr. Desmond had difficulties with, for example, cognitive flexibility. Although to the degree that that's really been canvassed I don't know, but certainly there wasn't any indications of overall psychopathology so ... But certainly after his deployment he becomes more cognitively restricted in the sense that he becomes increasingly focused on a narrow band of different themes, right. So whether that's work-related things or things related to his leaving the military or some of the issues related to his wife, he lacks that cognitive flexibility to problem solve around some of those issues so that's an active problem for him.

The active coping skills, again he has some deficits in that area. So, for example, I recall reading the material from

Ste. Anne's where he's given a coping card I think which I assume is a mechanism by which the person can sort of have a variety of things that they can do to help cope with stress that they're in and under at the particular point in time and they relate that he had difficulties utilizing that in a way so ... And the social support network we've talked about extensively in terms of where there are difficulties in that.

His physical health, as far as I know, was pretty good, although, I mean, increasingly ... certainly in psychiatry we utilize a technique called behavioural activation; it's common in depression. So as I like to paraphrase it it's the "fake it 'til you make it" concept, which is, you know, if you get up and do something even though you don't feel like doing it if you do it often enough eventually gee, I might be able to enjoy gardening or I'd like to go for a walk every day or those sorts of things. So to the degree that that was an issue or not for Mr. Desmond I don't know.

And then finally, the issue of a moral compass comes into play with issues around how one feels about the whole experience of being in the military and the service that you've done and those sorts of things. So that concept of, I think, moral trauma is the phrase that gets used these days.

Q. I think I've heard His Honour mention a concept of moral injury.

A. Moral injury.

Q. Are you familiar with that concept?

A. I've done some reading about it and I've certainly seen it although I didn't immediately sort of key it to the term itself. It relates to the idea that apart from the sort of actual trauma that a person has experienced and its immediate psychological sort of impact that moral injury arises from the difference between or the distance between the person's own moral views of a situation and those activities in which they are required to participate.

So for somebody in the Forces they're, by definition soldiers, so they have to do the things that soldiers do like shoot at other people, for example, and stuff like that. So that can cause a moral injury and if that's against your sort of moral code. Some of the other writings on moral injury talk about sort of difficulties that people in the military may have with sort of the chain of command and how decisions get made and those sorts of things, which is part of that picture as well.

Q. We've heard/seen that Lionel Desmond had disclosed to one of his healthcare providers about the impact of seeing a

child with a weapon at some point; I can't remember to whom he disclosed that to. Is that sort of a definition of what could perhaps could be a moral injury if he's struggling with that or no?

A. Yeah, that's a good point. I think that that would constitute ... in my mind that would be a moral injury. In some of the individuals that I've seen with PTSD some of the things that really trouble them the most are, for example, you know, if they're first responders and they've come across accident scenes where they have to respond to children or something like that, that that ... because we all have this normative notion that children should have a carefree life experience and they shouldn't be burdened with the things that adults are until such a point in time and to have somebody sort of summarily removed from the world under such circumstances would be a moral injury to somebody who experiences those things.

Q. How does a psychiatrist go about treating a moral injury and is it wrapped up in PTSD symptomatology or ... And in Lionel Desmond's case.

A. Well, it's wrapped up in the PTSD symptomatology inasmuch as it would be a focus of one of the ... well, you would get the person to sort of have a listing of the traumatic

experiences that bother them the most and part of the work would be the prolonged exposure. But I don't think, and I'm not an expert in the area, that you would do prolonged exposure around moral injuries but that would be sort of a topic for discussion about how do I make peace with what I've done. How do I come to reconcile my beliefs with the actions that I had to do as part of my work, for example.

Q. And outside, I guess, of some of the treatment that Dr. Rogers had done, in the records what you've reviewed, did you get any sense of whether or not the professionals that interacted with him were able to get to PTSD trauma treatment and that sort of moral injury sort of aspect to his profile? Were they ever able to get there?

A. Not that I saw although I'd have to review. The person that would probably would have had the most success if she'd been able to do it would have been Dr. Rogers, in that if she ... whether she canvassed that as a specific issue with him or not I don't know. I didn't read through all of the day-by-day notes.

Q. Do you have any sort of views as to ... Dr. Murgatroyd had stressed he had seen Lionel Desmond over a year before Lionel Desmond eventually is referred to Ste. Anne's and a

consistent theme in his reports was that he couldn't get to the treatment. The instability was sort of in the way and needed to be stabilized, couldn't get to the treatment. And then we have him in Ste. Anne's, they can't get the stability and you indicated it never appears to be achieved when he leaves St. Anne's.

What do you think was getting in the way of Lionel Desmond's ... and I know it's probably not a simple question, getting in the way of his stability and achieving it?

A. As I think about it I think that one of the ... there were probably two major factors. One is that a part of his PTSD was that it was focused on symptom clusters related to the hyperarousal symptoms. So to that extent he had significant issues with sort of irritability and ongoing issues related to becoming upset over what others might perceive to be relatively a trivial event, so that's one issue.

The other would be that, of course, the ongoing issues with his partner would feed that issue as well so that created an environment where his emotional dysregulation, as we refer to it, was such that they had a lot of difficulty getting that under any kind of control, which can happen and is very difficult to manage when it does.

So that means that in the absence of being able to do that you wouldn't really be able to get some of the trauma work because you would be essentially crisis-driven. So every time you would see the person you would have to deal with sort of just getting the individual calmed down with respect to the issue of the day that had arisen.

(15:10)

Q. And we see, you know, therapist Catherine Chambers, and you're familiar with her records, retained in about two months prior to the tragedy and she testified that she had yet to really sort of build the rapport with Lionel Desmond even to begin the aspect of visiting the idea of trauma treatment.

Do you have ... you have a unique opportunity to sort of see things in hindsight. Are there any things you see that could have perhaps assisted with his stability as he's coming out of Ste. Anne's and in those last six months or so before the tragedy?

A. Well, for me as a psychiatrist, of course, there's always some pharmacological tricks that I could have tried, for example, but to what degree they would have been all that effective I don't really know. But we often utilize things like mood stabilizers for individuals with emotional instability to

the degree that that works, that would be one strategy.

The other would be I think that ... and for Mr. Desmond, if he couldn't have emotional stability coming out of Ste. Anne's even if he'd had sort of ... and I don't mean domestic tranquility but just sort of a social environment where he could essentially be at peace where he didn't come into conflicts on a regular basis, for whatever reason, would be helpful in sort of turning that corner so that he could practice some of those coping strategies perhaps that he'd learned at Ste. Anne's.

Q. So I guess strategies that would sort of try to structure his environment where you remove certain stressors, is that what you mean?

A. Well, or to the degree that that's possible to do so, but at least to sort of minimize the stressors to the extent that you can.

Q. In terms of pharmacological treatment, we know that when Lionel Desmond ... as you're aware, he had a long history of non-compliance with medication and reported side effects. We know that when he left Ste. Anne's one of his prescriptions hadn't been covered originally out of the gate, there was some confusion. He was prescribed ... if I could have one moment.

A. I think he was on quetiapine and Sublinox.

Q. Yes, it was Sublinox, I just ... yes. So when he left Ste. Anne's Sublinox and zolpidem are they the same?

A. Yeah, they're sleeping medications.

Q. So he was prescribed ... one of the prescriptions was a sleep medication that he was given and it was a fairly consistent medication. So when he left Ste. Anne's in the middle of August he contacts his Veterans Affairs' worker and indicates that the prescription is not covered at his pharmacy, so he reaches out to her to see if Veterans Affairs could have it covered. That's August 24th. We know that Lionel Desmond, he was very rigid in what he paid for and what he didn't pay for.

He calls back again a month after that in September 22nd, 2016, and the Veterans Affairs' notes indicate that it's still that arrangement hasn't been made. And it's unclear whether Lionel Desmond ever did get that prescription filled. Indications would seem that he didn't because he's calling asking if it's going to be covered.

Knowing Lionel Desmond's profile and the history of non-compliance with medications and what you indicated today about you would have tried maybe a different approach with it, what sort of impact would it have that Lionel Desmond is going

without medications through some of his own doing, I guess, for a period of time when he leaves Ste. Anne's?

A. I think there would probably be both potentially physiological and then some psychological effects. So physiologically one of the issues that we have with hypnotics in general of which Sublinox is an example of what we call a Z drug or a Zee drug, depending on where you're from, would be that they tend to be inefficacious after so many weeks. So they're only good for so long and then they don't tend to be very effective although some people stay on them for very long periods of time so ...

So Mr. Desmond not having it probably didn't have much of a physiological effect on him because I'm not convinced that after all the time he probably would have been taking it that it was particularly effective for him anyway, just from sort of my knowledge of those substances.

I think the bigger impact would be psychological in the sense ... and you've talked a little bit about sort of some of Mr. Desmond's rigidity but that matter smacks of a certain sense of sort of being very determined to exercise his rights, if I could put it that way. So that the idea that, you know, his medications not being covered is not just some sort of snafu in

the system but it's a slight. So it's something that continues to rankle and cause aggravation for him rather than, you know, Yeah, this happens and I just kind of got to put up with it sort of thing.

Q. In terms of a pharmacological standpoint, at page 16 you refer to Lionel Desmond, you say "Mood was variable, often reacted to external stressors." Was the nature of his condition such that medication was sort of an important element to his stabilization in your opinion?

A. Well, I recall that he was diagnosed with both post-traumatic stress disorder and major depressive disorder, so the cornerstone for MDD, major depressive disorder, would have been a psychopharmacological approach, which Dr. Joshi had initially started. And for much of the time that he was under care he was on a drug called Effexor. Venlafaxine which is the generic name for it. So that would be a standard treatment for MDD.

The problem is, it came up in our discussion this morning, was that over the time, for example, that he saw Dr. Joshi there would be some times where he would be doing good and then other months where he was doing poor and that seemed to reflect more a number of external stressors, whether that was work-related stressors or stressors in the relationship that had come into

play. So in that sense, although the antidepressant could be useful it would be generous to think that it would really substantially impact on his mood and keeping it stable I would think.

Q. What about the sleep medication?

A. Sleep is a common problem with PTSD. It's one of the hyperarousal symptoms. So problems with sleep and concentration are part of that symptom profile, so it's an issue that we deal with in a number of different ways. So the short-term Z drugs like Imovane and zopiclone, zolpidem are some of the standard ways that we do it. Sometimes we use low-dose antipsychotics like quetiapine or low-dose antidepressant medications like trazodone to assist with sleep so ...

Q. So we have a ... you talked about hyperarousal symptoms and the importance as it relates to Lionel Desmond as it related to his risk and the profile that he had with hyperarousal symptoms and then now you've linked sort of that importance with pharmacological treatment. We know that while he was part of the military he had Dr. Joshi. At times he was sort of resistant to the idea of medications but he did take them at various points.

When he went to the OSI Clinic in New Brunswick he had an

acting sort of psychiatrist which was Dr. Njoku. Similar thing there as well, prescriptions, there was a reluctance but there were periods of time where he complied.

He goes to Ste. Anne's, he has Dr. Ouellette who prescribes prescriptions. There's some resistance and non-compliance at times but he takes them and there's a monitoring again by Dr. Ouellette.

When he leaves Ste. Anne's in August, are you aware of any sort of psychiatrist that's sort of assigned to that team which is sort of overseeing medication compliance and interacting with him and talking about the importance of compliance or is that aspect sort of missing in the last six months of his life? Other than going to an ER setting.

A. Well, I think that eventually he does get connected, of course, with Dr. Slayter and Dr. Rahman at the very end and then Dr. Slayter makes some changes to his medication. But prior to that his medications were being managed as I understand it by a family physician, although he didn't have a family physician so that created a problem in getting those medications covered.

Q. So looking at this, was it important, I guess, for Lionel Desmond to have a physician when he leaves Ste. Anne's,

unstable in many ways, to have that presence which is a recognized psychiatrist or a doctor to monitor those compliance with medications?

I know that Dr. Njoku is still there, I guess, technically in New Brunswick and Lionel Desmond has chosen to sort of exist in Nova Scotia.

(15:20)

A. Well, I think inasmuch as the medications were part of his overall treatment plan there needed to be some oversight of those medications, whether that in the short term could be comfortably be done by a family doctor or a psychiatrist it's hard to say. But the problem was was that neither were easily available to him, I guess.

Q. At the middle of page 16 the paragraph where you note "Unfortunately, transitions were difficult for Mr. Desmond ..." the second line you say, "In psychotherapy, consistency over time with a therapist with whom one has a good match can be critical to success."

Now we know Lionel Desmond, he had moved around quite a bit, but do you think Lionel Desmond, not through necessarily the fault of anyone, but do you think there were aspects where the consistency that he might have needed was not present?

A. We certainly know that in psychotherapy that, I mean, there are ... as you will be aware, many schools of psychotherapy, many approaches to psychotherapy, but we understand that in psychotherapy there are some bedrock considerations as I think of them and that can ultimately sort of impact on the ability to succeed with the person.

So some of those are things like consistency and the ability to have a positive relationship with the therapist with the patient and the patient with the therapist. So in that sense because every time you introduce a new therapist there's a learning curve, so to speak, on both parties' part as you get to know the client and the client gets to know you. There's both opportunity and risk in terms of sort of that relationship ultimately working out or not working out.

As I often suggest to patients if you find a therapist that's working well with you and you're getting benefit from it don't change them, you know, as much as possible. So to the degree that you could have continuity of the same care provider, given that it was a positive relationship that was working well would be something that would be very useful.

Q. Okay. I want to ask you a few questions as it relates to cannabis and mindful of some of my friends within the room

and questions they may have surrounding cannabis I'll start by, I guess on the record, there's no indication that in a significant portion of time that leads up to the tragedy that Lionel Desmond was consuming cannabis or, in fact, on the day of the tragedy that he was prescribed any cannabis that he was taking. We'll sort of set that aside.

But I want to ask you a little bit because we did hear a whole lot about cannabis and I want to ask you a little bit about cannabis and maybe the onset of psychotic disorder such as schizophrenia and I want to be very brief because was there any indication that Lionel Desmond had a psychotic disorder or schizophrenia?

A. Not from my review of the files, no.

Q. So if you could tell us just very briefly, you touched upon it in your report at page 19, cannabis and what the current status of literature is with respect to cannabis and psychiatric disorders.

A. I'll be brief because you've had considerable information about cannabis and its colourful history over thousands of years so we'll skip all that part of it. But it's an area that continues to be one of active research, but I think one of the issues with cannabis, particularly as it's

researched, is that it's very difficult to draw solid conclusions from much of the evidence and that has to do with, in many ways, how we construct experimentation in medicine.

So, as you're probably aware, so in medicine the gold standard would be what we call a double-blind trial, right. So you're given pill X but you don't know whether pill X is a placebo or the active pill. The patient doesn't know, the physician doesn't know. You run the trial and then you break the code later on and you determine whether the people that got the active drug did better than the people that didn't get the active drug, right. So that's sort of a double-blind trial.

One of the problems is that it's very difficult to construct a double-blind trial for cannabis, it's a very distinctive product, it's pretty hard to hide whether you're getting it or not so that's one issue.

There's a lot of potential issues related to bias in the research because often people that are drawn to the research studies either have a history of positive or negative use of cannabis already so they bring potential sort of bias into the whole process. So there's a lot of ongoing research in cannabis products but it's very difficult to extract some of the data in a reliable kind of way.

There's ongoing issues about the cannabis products themselves in terms of the degree to which you can have a pure extract of, say, CBD versus THC and all those sorts of things, so that's sort of a continuing sort of issue. So it just creates a very complicated environment in terms of the experiments.

But the latest literature that I've reviewed on the matter, particularly as it relates to psychiatry, is that there is really ... the art of the science at this point is still at a point where it couldn't be recommended that cannabis be used for any specific psychiatric disorder.

So we do know that, for example, that for individuals who have a risk for development of schizophrenia, so family members for example, who use cannabis heavily they are at a greatly heightened risk of developing a psychotic disorder, for example.

We do know that the Canadian Psychiatric Association when cannabis was made legal a few years ago, had lobbied to make the age where it was legal 21 rather than 18 because that's more closely aligned with sort of the maturation of brain development, so after which the risk for developing a psychotic disorder would go down with heavy cannabis use.

We do know that cannabis can be useful in some chronic pain

conditions like certain neuropathic pain disorders and stuff like that. There's some preliminary evidence that it can be useful in PTSD but the problem is is that there's also evidence that says that it's not useful in PTSD so it's hard to draw a conclusion.

So the most recent review that I saw as well as a very thorough review done by the National Academy of Sciences in the States from 2017 both concluded that it was too early to recommend cannabis for use in any psychiatric disorder.

Q. I'm just going to bring up an exhibit, 333. You footnoted in your report a particular study, Doctor. Is this the study you're referring to?

EXHIBIT P-000333 - FOOTNOTE 5 - THERIAULT - thc2

A. Yes, that's one of several that I've looked at but that's the most recent one, yes.

Q. And I guess ultimately what is the sort of conclusion based on ... and I believe that study was done when?

A. 2020.

Q. 2020. And what was the ultimate sort of finding and recommendation of that study at this time?

A. The ultimate conclusion was that it would be premature to recommend cannabis for any specific psychiatric disorder but

there should be further research into cannabis products and CBD being more promising than the THC variant and that there might be some future indications moving forward but not at the moment.

Q. And so, Doctor, I guess I want to bring this into Lionel Desmond. In terms of your review of the evidence, we know at various points he had reported that he, in fact, wanted to go off cannabis, he didn't want to take it anymore. At one point he disclosed it sort of increased his intrusive thoughts regarding Shanna Desmond. Are you able to comment whether or not, in your review, Lionel Desmond found that cannabis use was of any benefit to him?

A. My review of the documentation in its entirety would suggest that ultimately he decided that it wasn't of benefit to him. He had, as you said, used it periodically through a course of time but in the lead-up to his going into Ste. Anne's he had had to come off of it because they had a requirement that he be abstinent from cannabis for a period of time. But my recollection is that he, by that time, had decided that it wasn't particularly helpful anyway and so that he had been abstinent from it by the time that he went into Ste. Anne's, and as far as I know there wasn't a return to cannabis use after his discharge from that facility.

(15:30)

Q. If we look at sort of rehabilitation with Lionel Desmond as something that goes as far back as at least 2011 from the early sort of contact he has with professionals in Canadian Armed Forces, we know that he was prescribed at various points upwards of 10 grams of cannabis a day by a physician in New Brunswick.

I'm just curious, he's reported a number of things about ... I don't know if I want to call them side effects but sort of negative reactions with cannabis. My question is I guess, from a rehabilitative standpoint, if you have Lionel Desmond, he has his profile, it's described by Dr. Murgatroyd, it includes intrusive thoughts about his wife, it includes a number of sort of PTSD symptoms, he has a lot of social issues that are happening. I'm curious to know what your views may be on how cannabis use during his one aspect of the time, that is his rehabilitation, if any effect that might have had on him, his rehabilitation? Does it sort of stagnate his rehabilitation possibly in any way? Do you have any views on that?

A. There are a couple of issues I would consider in respect to that question. So we know that sometimes cannabis users report a heightened sense of paranoia on cannabis, so that

would be an issue. And I would be particularly concerned about anybody that had any sort of pre-existing sort of issues around paranoia, meaning sort of mistrust of others or suspiciousness about others and the use of cannabis products, so that would be one area.

The other would be that depending on the amount of use and its proximity to when Mr. Desmond, for example, was seeing or dealing with a therapist it could impede the therapeutic process if ... you know, to be perfectly blunt, if you're going to a therapy session under the influence of a substance. So that could certainly impact negatively on his progress.

Q. But I guess in fairness to Dr. Smith, I mean he hadn't reported to Dr. Smith any of the negative side effects that he had disclosed to others. He, in fact, said it helps him with sleep, it helps him. Dr. Smith was hearing sort of positive things.

I guess in terms of Lionel Desmond there was indication that he struggled with alcohol as well, consumed quite a bit of alcohol per week. Is there sort of a compounding effect that another sort of ... I guess cannabis isn't technically a depressant, I don't want to give evidence, but is there ... is there a concern when you're prescribing another thing that has

depressant qualities on top of something that's already sort of a depressant which is alcohol?

A. Well, certainly alcohol would be a significant issue in that regard. I mean alcohol is, of course, a depressant, that's been pretty clearly established. So often people will say, you know, I drink because it makes me feel better and then they almost always follow up with, But then I just feel worse the next day. So ultimately it's a self-defeating exercise to consume alcohol in large quantities to deal with depressed mood which people, of course, often do. So that's a live issue.

The other issue around alcohol though ... again, it's not ... it doesn't seem to be an issue that's at play towards the end of Mr. Desmond's life is that substance use disorder is a significant risk factor for violence, of course.

Q. In terms of moving on to what Dr. Slayter had referred to as post-traumatic brain disorder, I want to ask you a few questions about that. Page 17 of your report.

MR. RUSSELL: I don't know, Your Honour, when you had intended for an afternoon break. I just want to make sure.

THE COURT: I hadn't really thought about it.

MR. RUSSELL: I'm just thinking of everyone else.

THE COURT: Well, I guess I should think about everyone

else.

MR. RUSSELL: Not to ...

THE COURT: Sorry. Excuse me. Wrapped up in my own little world here.

All right, well, why don't we take 15 minutes, let everyone just kind of stretch their legs and have a little sip and we'll come back in 15 minutes then. Thank you.

COURT RECESSED (15:35 hrs.)

COURT RESUMED (15:50 hrs.)

THE COURT: All right, thank you. Just hang on for a minute, Mr. Russell, just before we start. So I know that we've all been suffering through the heat in this courtroom all day and ... well, I have and I know others have, and we've made that fact known to those that are responsible for maintaining this building and the temperature in it as well.

That message has been passed on several times during the course of the day with little being done to rectify the problem. It remains hot in this courtroom. We're coming back tomorrow at 9:30 to deal with Dr. Theriault. You're back tomorrow morning, Dr. Theriault?

A. I am, Your Honour, yes.

THE COURT: Okay. My inclination is to adjourn for the

afternoon now. We're only here for another 45 minutes, at any rate, and rather than have people suffer through another 45 minutes of this room, I'm going to adjourn for the day to return tomorrow morning at 9:30 in the expectations that the room will be at an acceptable temperature for the rest of the day. All right?

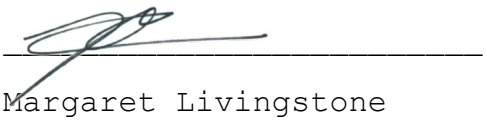
Sorry for the inconvenience but at the end of the day I think that the minor inconvenience of adjourning early will be offset by the fact that we don't have to suffer through the temperature in this courtroom any longer.

Thank you. We're adjourned 'til tomorrow morning.

COURT CLOSED (15:52 hrs.)

CERTIFICATE OF COURT TRANSCRIBER

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



Margaret Livingstone

(Registration No. 2006-16)

Verbatim Inc.

DARTMOUTH, NOVA SCOTIA

November 10, 2021