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 2, 2021

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COURT OPENED (09:34 HRS)

THE COURT: Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Mr. Russell. Good morning, Doctor.

DR. THERIAULT: Good morning.

DR. P. SCOTT THERIAULT, still affirmed, testified:

DIRECT EXAMINATION (Cont'd.)

MR. RUSSELL: Thank you, Your Honour. Good morning, Doctor.

A. Good morning.

Q. After yesterday's long day, I thank you for coming back.

A. You're welcome.

Q. Not as though you had a choice.

A. That's true, yes.

Q. I think His Honour is holding you here.

So, yesterday, we were going to move into the area that was

Dr. Slayter's diagnosis of post-traumatic brain disorder and, in particular, if we turn to page 17 of your report. So we know Dr. Slayter diagnosed him with post-traumatic brain disorder, and then you had indicated in the second paragraph, "The matter of 'posttraumatic brain disorder' cannot be easily rectified."

I guess, so, first, what is posttraumatic brain disorder?

A. Well, that term, "posttraumatic brain disorder" doesn't exist in the DSM-V which is the psychiatric physiological manual that we would use, so we would diagnose either a minor cognitive disorder or major cognitive disorders would be the preferred terms in the DSM, although you can have, of course, a minor or major cognitive disorder due to some sort of traumatic event - concussions or major head injuries, those sorts of things.

Q. So Dr. Slayter picks up on a number of things that signals to him those limitations that need to be further examined and, in your review, you note, "The matter of 'posttraumatic brain disorder' cannot be easily rectified." So what do you mean by that?

A. Well, in part, it has to do with that particular terminology which, as I've just indicated, doesn't exist in the DSM. The other issue is that I think there's some lack of

clarity around the degree to which Mr. Desmond had suffered a brain injury and whether there is any medical sort of clarity around that, you know, CT scans, MRI scans, those sorts of things. There had been some consideration throughout his course of treatment about neuropsychological testing. That had never been undertaken, so that would be sort of a process that we would use generally to sort of help to delineate if somebody has significant cognitive impairment secondary to some sort of head injury.

Q. And in your review of the evidence, do you think there was evidence there to support the benefits and need for neuropsychological testing?

A. Well, certainly, Mr. Desmond often complained about cognitive impairments - difficulties with concentration and focus and memory and those sorts of issues; so, in that context, it would be useful to have neuropsychological testing to help sort through some of these potentially confounding issues. The other one being, in post-traumatic stress disorder, that one of the symptoms that people often develop are difficulties with concentration and focus, and that's true with depression as well, which Mr. Desmond had also been diagnosed with, so a neuropsychological assessment would help tease out those

different contributing factors to that.

Q. And, in your review, were there a number of points along the way that would be suggestive if he had difficulties with concentration and focus?

A. Well, it's difficult, in reviewing the file retrospectively, of course, because it's something that's certainly noted consistently throughout the file by various clinicians that he interacted with. There's no formal testing of that that I saw anywhere that would sort of solidify that as an issue, but it's certainly reported on a regular basis.

Q. I'm wondering if we could look at Exhibit 278, and, in particular, page 6.

THE CLERK: Did you say page 6?

(09:40)

MR. RUSSELL: Page 6, yes, please.

Doctor, probably three-quarters of the way down, it says, "Client notes he fell." The document you're looking at here would've certainly been provided to you. This was from May 25th, 2015. So we're probably at least a year-and-a-half prior to the tragedy of January 3rd, 2017. This was a transitional interview which was standard when Lionel Desmond is transitioning from the military to civilian life and he's going

to go through Veterans Affairs. So they did a transitional interview.

At that time, you can see there, one of the things that is noted is that: "He reported he fell on his head while jumping out of a plane and he was reported to having trouble remembering things and retaining information."

So there's a sort of history of reports similar to that but this is sort of very early in time. Is this the sort of thing that may prompt someone such as yourself to sort of start to wonder if a neuropsychological assessment may be something that needs to be examined?

A. Certainly, for somebody that ... So, for example, if we look at things like minor cognitive impairments arising from, for example, a concussion, which is a common example, one would expect to see resolution of those symptoms within usually three to four months for a minor concussion. If a person has had an incident where that doesn't resolve, and it doesn't resolve in a small percentage of people, then you would expect ongoing complaints of difficulties with concentration and focus, and, in that context, it's often useful to get a neuropsychological assessment just to sort of ... You're always interested in determining whether there are ways to mitigate any of those

issues, whether there are techniques that the person can use or other strategies that they could use to help compensate for any difficulties with concentration or memory.

Q. And so that was sort of what my question was going to be is that if you're interested in embarking upon a rehabilitation plan that involves various forms of trauma treatment, is it important to sort of have a baseline understanding of the client or patient you're treating in terms of their abilities. In terms of comprehension.

A. Certainly. I mean any clinician will normally, in the course of their assessment and then on an ongoing basis, make sort of a general judgement about the person's level of concentration and ability to focus on the issues at hand because, of course, it's critical in sort of doing the therapy that the person is able to follow you and concentrate and follow through on any instructions that you may give in terms of the homework that you often get in psychotherapeutic endeavours.

Q. Okay. And it's not going to be my intention to review the number of points along the way where Lionel Desmond reported similar things and clinicians noted that he has difficulty concentrating, but I want to take you through a quick sequence, starting with Exhibit 244, page 79. I'm going through a

sequence of things and then I promise there are questions based on it. I just want to put the foundation before you.

THE CLERK: Page 79?

MR. RUSSELL: Page 79, yes. If we could scroll down.

A. Thank you for blowing up the screen, by the way.

THE COURT: I find it very helpful as well.

MR. RUSSELL: If we look to the middle of the page, you're going to see a line that starts with, "Writer intended on giving psychoeducation ..." Do you see that?

A. Yes.

Q. So, Doctor, this, what you're looking at, is a document, it's an entry from Dr. Murgatroyd from the OSI Clinic in New Brunswick. Now, as we know, Dr. Murgatroyd treated Lionel Desmond at least between May 7, 2015, and up to May 31st, 2016, before Lionel Desmond is then officially at Ste. Anne's. So this particular entry from July 3rd of 2015, Dr. Murgatroyd notes: "Writer intended on giving psychoeducation related to stress response and breathing techniques, but Desmond was again difficult to redirect and writer did not have enough time during the session."

And then if you go down further, you see a line where it says, "Today, we talked further ..."

A. Yes, I found it.

Q. So I'll read that:

> Today, we talked further about the possibility of doing trauma work; however, Mr. Desmond was physically distressed by the thought of doing trauma work at this time. He became distant and did not want to speak for several minutes during the session.

So this is something that's documented by Dr. Murgatroyd, July of 2015.

I'm wondering if we could move to another exhibit. It's Exhibit 117, page 1. If we could scroll down. If we look to ... I promise it's there. Where you see, "The veteran is open ..."

A. I see it.

Q. You see it? So I'll just read that. It says:

> The veteran has proven he is open to ...

Before I read it, I guess this a case document note from Veterans Affairs case manager, Marie-Paule Doucette, in January of 2016. So, earlier, it was July of 2015, Dr. Murgatroyd, so in January of 2016, this is a note made by Veterans Affairs case manager, Ms. Doucette. And she notes:

DR. SCOTT THERIAULT, Direct Examination

> The veteran has proven he is open to receiving psychological help. The mental health professionals he has connected with report an inability to begin working through his military-related trauma due to ongoing instability, i.e. disability symptoms of PTSD. For now, he maintains regular contact with his mental health team with hopes of soon engaging in stabilization and structured treatment they have formally recommended.

So if we turn to number three - I promise there's going to be a series of questions - which is Exhibit 254, and would be page, I believe it's 272. If we could scroll down. Sorry, I'm looking for the ... Julie Beauchesne, so it's probably the next page. Down as well. It's under the "Recommendations of Occupational Therapist".

(09:50)

So what you're looking at here, Doctor, is the Interdisciplinary Discharge Summary that was prepared while Lionel Desmond was leaving Ste. Anne's. And a number of notations are made by Ms. Beauchesne who is the occupational

therapist and as it relates to recommendations for, ultimately, the neuropsychological testing. You see where it says, "In that context ..."

A. Yes.

Q. And I'll read that. It says:

> In that context, Mr. Desmond gave his consent to screening evaluation for mild cognitive dysfunctions. The MoCA test was used for this purpose. The results of the evaluation did indeed indicate the presence of mild cognitive dysfunction. The nature of the test done does not allow the identification of the proportion to which different elements may have influenced the performance (and she puts) i.e. performance anxiety.

I wonder if you could tell us, what is a MoCA test?

A. MoCA stands for "Montreal Cognitive Assessment". It's a short test with a number of items that gives a total rating of zero to 30 on the test. It's considered a screening exam for cognitive impairment, the same way that we use another one called the Folstein Mini-Mental Status Examination, but the MoCA

has been around for a long time and is used quite commonly. As I said, it's a screening test and, in this particular document, the number is not given but, in general, scores of 23 or below would be considered of at least mild cognitive impairment on the screening test.

One of the things that you do need to remember, though, is that because it's a screening test, it can't make any definitive diagnosis and we would use it generally as a screener to consider whether other more informative tests might be required to be used.

Q. And more informative tests being, in this case, if he's scoring for the suggestion of mild cognitive dysfunctioning, would a more informative test be the neuropsychological assessment?

A. Yes, because a formal neuropsychological assessment would look at different domains of cognition in a more detailed way than the MoCA is able to do. The other thing formal neuropsychological testing does is help to sort out whether or not the cognitive impairments are due directly to some sort of head injury, for example, or whether it's due to other causes; for example, anxiety or depression or, in some cases, of course, neuropsychological testing is always looking for what we would

call "validity test"; whether the person is accurately reporting some of the difficulties that they're presenting with.

Q. So when you're trying to get a treatment plan put in place for Lionel Desmond which, on its face, appears to be presenting symptoms of PTSD, and what is the value in sort of understanding his source of mild cognitive dysfunction? From a treatment perspective, why is it important to know that?

A. Well, the advantage would be that if one had a more fulsome understanding of any cognitive impairments that Mr. Desmond may have had, then that would inform treatment providers of work-around, so-to-speak, you know, ways that you might need to work with the client in order to compensate for some of those difficulties, or strategies that you could use to assist the person to overcome them, or modifying your therapy technique so that you're not bumping up against the difficulties that would only serve to cause consternation to the individual.

Q. And how important is sort of knowing your baseline, I guess, for cognitive functioning of your client when it comes to, I guess, interacting with them when you're trying to put a treatment structure in place for them and for them to comprehend sort of what is going on, what is going to happen with their file, who they're going to meet with, what appointments are

being scheduled?

A. Given the complexity of those organizations and the multiple ... and I'm speaking here in the context of my own organizations that I work with, but I can only assume that it would be true for the military as well, that there's often multiple sort of processes that you have to sort of go through and applications that you make and people you have to contact, and all those sorts of things.

If you have difficulties with concentration, that could potentially create difficulties with coordinating yourself to get those done in a timely kind of fashion or you get frustrated like me trying to figure out my passwords on my computer, right? After while, you just give up.

Q. Okay. If we can scroll down, and under "Recommendations from Ste. Anne's" that we know, and Ms. Beauchesne ... If we could keep moving, it says:

> A neuropsychological evaluation is recommended in order to determine Mr. Desmond's cognitive capacities.

And then it goes further. And in that paragraph, it says:

> A functional assessment by an occupational therapist is also strongly recommended in

order to determine the client's actual functional capacities or limitation, having a clear portrait of the actual impact of cognitive deficits on the client's functioning, if any, will serve to orient treatment in that it will support the process of setting realistic therapy goals which are to help Mr. Desmond attain a satisfying level of participation in his activities and develop a sense of having an improved quality of life.

Now we heard from Ms. Beauchesne, but, as a psychiatrist who is involved in rehabilitation, I want to ask you a few things about that paragraph in that a functional assessment and what she notes as one of the important goals is that it will serve to (1) orient treatment. And if you can explain how that would be the case. How does a functional assessment and a neurological assessment serve to orient treatment? You sort of touched on it.

A. If you read the rest of that clause, that sort of helps set that response in context.

Q. Yes.

A. So we use functional assessments quite commonly at the forensic hospital where I work. And so we use them primarily for two reasons, and this would apply in this case as well, I think. One is you're - quite apart from sort of any specific cognitive issues, you're looking at the functional capabilities of an individual, which may or may not be the same. So, for example, we know that you may have individuals with some intellectual disability of some sort. And I'm not saying that that's the case with Mr. Desmond, but just in terms of explaining the area. They may have intellectual deficits, but, in terms of their performance abilities, they're relatively intact. So an occupational therapy assessment in that context helps sort of set a baseline for, at its most basic, you know, is this person able to live independently? Can they perform all the necessary activities of daily life that they would need to do? Those sorts of things. So that's part of a functional assessment.

The other part usually is an exploration with the individual and testing of what we call the "independent activities of daily living". Can they do things a bit akin to what we were just talking about? Can they organize themselves to get paperwork done? Can they make appointments? Can they

set up different streams of activities that need to be done in a certain period of time? And those sorts of things.

So those are useful to have from an occupational therapy point of view because given the findings from that, you can then develop treatment strategies that help sort of compensate for those deficits, if they exist, or, if they're significantly severe, you might have to make recommendations about other supports - external supports - that might be required for the individual.

Q. And is it fair to say that even PTSD alone, setting aside any sort of cognitive capacities, is PTSD alone in its presentation sometimes and its symptoms, add a level of disorganized thought to the patient or client?

A. They can certainly present that way because, often, if they're subject to intrusive thoughts, they have trouble clearing their mind, so-to-speak, so that they can focus on the activities that they're engaged in at the moment. So that's a common finding that you would see.

Q. Did you see, in your review, aspects of sort of disorganized thought as it relates to Lionel Desmond?

A. In the global review, I think there were several areas where he could present at some times as quite organized in his

interactions with other care providers, but, at other times, and I think you referenced one just a few minutes ago, where he would present as quite ... my term would often be "internally preoccupied", preoccupied with his own thoughts so that he was having difficulties focusing on the here and now, so-to-speak.

Q. And, I guess, so we could take an extreme example where there's extreme cognitive limitations to the point where someone's capacity is functioning at such a low level that they're incapable of sort of reading anything or comprehending very little. But, in someone like Mr. Desmond's case, from your review we heard a phrase, I guess, "driver of his own care", which sort of puts a level of sort of emphasis on Lionel Desmond using his best efforts to coordinate his care. Do you see sort of limitations as it relates to Lionel Desmond's ability to sort of navigate his treatment structure independent of sort of an assistance which ends up being someone like Helen Boone who acts as a clinical care manager?

(10:00)

A. To my mind, there's two aspects of that. One is that you want to honour the individual's ability to organize his own care in the sense that they make their own autonomous choices about what therapies and activities to be involved in or not.

But, on the other hand, if somebody has difficulties with certain organizational skills, for example, then that would suggest that perhaps they could benefit from added assistance in doing that, so whether that's a case manager or somebody that helps coordinate paperwork for them or go through those sorts of things.

I mean the information available would suggest that Mr. Desmond was certainly quite capable of independent living. He had his own home and he managed that home and he put it on the market and he sold it, which was the content of many discussions, I think, with people that he interacted with. So in that sense, he was certainly capable of independent living. But in some of those more focused areas of coordinating aspects of his care which could be very complicated, that seemed at times to be difficult for him.

Q. So do you think there was ... was there any benefit to having someone like Ms. Boone, a clinical care manager, earlier in time than when she was ultimately put in place about a month prior to the tragedy?

A. I think it would have been advantageous to have ... we talked yesterday about continuity of care providers but, to the same extent, to have a continuity wherever possible, of sort of

case management services throughout the course of Mr. Desmond's history would have been advantageous because that would have allowed him to have a single point of reference that he could go to to sort of assist him with moving the whole situation forward in terms of care that he required and the services that he would need.

As you transition from service area to service area, you run into the same difficulties with case management services as you would with clinical services in the sense that the new case manager would then also have to learn the whole file in order to sort of know where Mr. Desmond was in the course of his treatment and his care and how to coordinate those services for him.

Q. You indicated yesterday, and we had reviewed a number of aspects where it was very difficult and it was unsuccessful to really, other than Dr. Rogers, to get to that trauma treatment, so you talked about sort of dealing with the crisis of the day, I guess.

I guess from your perspective, how do you organize a very structured and comfortable and effective treatment structure with realistic goals for Lionel Desmond if you still don't know the results of, say, the nature of his cognition? How do you do

it?

A. Well, in the absence of formal neuropsychological testing, you would have to use your clinical acumen. So you would have, as a clinician, so either as a psychiatrist or several psychologists that Mr. Desmond saw, you would have some sense of what some of those cognitive difficulties may have been even in the absence of formal testing. So you ... essentially, to use the term you would have to best guess about sort of what those deficits were and you would try to work around those within the context of that understanding of it without the formal testing. Although that might create issues in terms of if you miss some particular sort of cognitive domain that's ...

Q. So putting your quality control lens on is best guess/ the best practice?

A. I think in a case like Mr. Desmond's that the neuropsychological testing would have been a very important part of his overall treatment plan. In general practice, it's hard to say whether it's best practice or not because the accessibility of neuropsychological services is a very limited body in mental health.

Q. Are you able to comment on ... we know for, I guess the better part of a two-year period before the tragedy, the

professionals indicated that they weren't able to even get to trauma treatment as it relates to PTSD. Are you able to comment on what, if any, effect that had on Lionel Desmond especially in the months leading up to the tragedy? So he's gone sort of two years without really effective trauma treatment.

A. Well, in the absence of any effective trauma treatment, then there would be no particular reason to think that there would be any amelioration of any of his PTSD symptoms, so they would remain active over that period of time and in some ways potentially could worsen as a course of the chronicity of his illness.

Q. Did you get any sense that his symptoms remained the same, reduced, or got worse in the sort of year leading up to the tragedy? Or I guess we'll put a timeframe on when he leaves Ste. Anne's in August of 2016.

A. The information that I have, and we had discussed some of this yesterday, was that of course he went to Ste. Anne's because they were having difficulty stabilizing him at that point, and he'd gone to Ste. Anne's for that purpose. That was ... the treatment at Ste. Anne's was really only marginally successful in stabilizing Mr. Desmond so that when he left Ste. Anne's, his symptoms were still quite active. And that

continued on through the course of his history until the end of his life, unfortunately.

Q. You indicated that symptoms of hyperarousal, as it relates to PTSD, are tied with risk for violence. Is that correct?

A. As part of that study that we reviewed yesterday in military, in particular, where the PTSD symptoms of hyperarousal correlated with an increased risk of violence, yes.

Q. And you noted that Lionel Desmond had a number of hyperarousal aspects to his PTSD diagnosis?

A. Difficulties with sleep, anger and irritability.

Q. And are you able to clarify how prominent those hyperarousal symptoms were?

A. Certainly, they seemed to form a major theme in his conversations with people and not only in relationship to his marital partner but irritability sparked by other issues, as well, so it seemed to be sort of an ongoing issue for him on a go-forward basis.

Q. I'm wondering if you're able to comment then if he leaves Ste. Anne's in August of 2015, he's unable to sort of successfully get treatment for his PTSD and, in particular, his hyperarousal symptoms and hyperarousal symptoms are linked to a

risk for violence, is there anything concerning about that sort of link from your perspective?

A. I think in a more general sort of way, the hyperarousal symptoms inasmuch as that they often constituted symptoms of anger and irritability would have been a significant target treatment because, of course, that's something that you would ... well, to back up; quite frankly, it's difficult to provide treatment to somebody if they're angry with you all the time. So that would have been a major sort of component of his treatment plan.

Q. Did you see any evidence in your review whether or not Lionel Desmond had received any treatment for the hyperarousal aspects of his PTSD between leaving Ste. Anne's and ultimately the tragedy of January 3rd, 2017?

(10:10)

A. I think I might need to think about ... I know that when he saw Dr. Slayter, that Dr. Slayter made some minor changes to his medication. And when he left Ste. Anne's, he was on quetiapine which is a medication we would commonly use to sort of try to help with some of those symptoms.

Q. Okay. And are you able to point to any sort of other aspects other than the efforts that Dr. Slayter made?

A. Not really in the timeframe between when he came back to Nova Scotia and January the 3rd because, of course, he had limited contacts with mental health professionals in that period of time and he was really just getting to be known by them as a ... (inaudible - talkover).

Q. Would it have been beneficial for someone like Lionel Desmond to know or have organized when he left Ste. Anne's a team of professionals, or even a professional, that could address his hyperarousal symptoms at the first opportunity, so a continuation the moment he gets out of Ste. Anne's? Would there have been a benefit there?

A. There would have been a benefit when he left Ste. Anne's to have many of those issues sort of nailed down, for want of a better term, sort of a warm handover to the receiving team with some discussion of some of those issues as we canvassed yesterday, including the hyperarousal symptoms.

Q. Do you think Lionel Desmond would have benefitted ... we know that he finds Dr. Slayter. And as you indicated, Dr. Slayter is able to make adjustments to medication. And he finds Dr. Slayter through a doctor at the clinic in Guysborough who makes the referral, who doesn't know the background or detail of Lionel Desmond's ... details of his condition.

Do you think, looking at this sort of retrospectively, knowing Lionel Desmond's profile, do you think there was a benefit in someone assisting him at the outset to say, Here's who you should be speaking to and we can get you in touch with this person to deal with your hyperarousal, as opposed to Lionel Desmond with his condition navigating through on his own, I guess, or with his wife, the Nova Scotia healthcare system?

A. There is really two pieces to that. So, in general, case management services that I'm familiar with, case managers are not necessarily clinicians. So they might not be able to pick up on some of those particular aspects about the hyperarousal and stuff like that, but they would certainly be part of the picture in terms of making sure that the general care for the person is coordinated; You should be seeing this person for your chronic pain or your hypertension or whatever the case may be; you know, We've organized this sort of meeting with somebody about your PTSD symptoms but they ... often, because they're not clinicians and because their job profiles are usually around coordinating services, that they might not have it in that nuanced a fashion, I guess.

Q. Okay. I want to turn to a number of aspects of what's paranoid personality disorder and borderline personality traits.

Page 17 of your report, we note ... and I guess I'll ask you, are you familiar with Dr. Ouellette's opinion that was Lionel Desmond did not have paranoid personality disorder but, rather, he had mixed personality traits?

A. I was, yes.

Q. And do you agree with that assessment of Dr. Ouellette?

A. I think that it was useful for Dr. Ouellette to distinguish between personality disorder and personality traits because personality traits are, of course, just that. Personality disorder is a different kettle of fish altogether, so to speak. So in that sense, yes, I would agree that Mr. Desmond had paranoid personality traits. The more interesting question for me is whether he had borderline personality traits which I think was also described by Dr. Ouellette.

Q. And when you say sort of more interesting to you were borderline personality traits, I guess if you could tell us what they were. What are borderline personality traits, first, and then what borderline personality traits Lionel Desmond may have had.

A. In general, in psychiatry we differentiate between three broad categories of personality disorder. So for

simplicity, we simply call them Clusters A, B, and C. But the Cluster A personality disorders are individuals with ... the most common ones there are paranoid personality disorder, schizoid and schizotypal personality disorder.

The Cluster B personality disorders are what are often referred to as the dramatic personality disorders. So the most notable ones there are borderline personality disorder and the antisocial personality disorder. And then the Cluster C personality disorders are what we would call the neurotic or avoidant ones, so people with sort of anxious sensitivity and those sorts of things.

So for Mr. Desmond, one of the issues for him in particular was this notion of emotional dysregulation. So he could go from being very calm to being very agitated quite quickly. Those periods of agitation would often be sparked by perhaps ... in retrospect, could be seen to be relatively minor issues but which, to him, were significant in their impact. So that mood lability, as we would call it, that's a fairly central feature of borderline personality disorder. So in that sense, that would be borderline personality trait in the sense that it existed with Mr. Desmond without the whole panoply of all the features of borderline personality disorder.

And similarly with paranoid personality traits. Generally, paranoid personality traits are found in individuals who are hypersensitive to the rejection of others. They're mistrustful of others. They are concerned that other people might not have their best interest at heart, that given the opportunity they may wish to harm them, although that would be an extreme but at a minimum, sort of not treat them fairly. So that's a broad sort of view of sort of paranoid personality disorder.

So with Mr. Desmond, of course, he had paranoid personality traits in the sense ... particularly around his issues with his wife and sort of his concerns about his finances and her relationship to those issues. So those are paranoid personality traits. I think that in the period of time that he was at Ste. Anne's that that was seen by the staff there because he reached a point where he wasn't sure that the staff were supportive or that he could trust them. So, again, that would be a paranoid personality trait.

Q. So you've indicated that, in your opinion, he had paranoid personality traits and borderline personality traits. Are you able to sort of separate them or able to comment whether they were distinct and separate from PTSD diagnosis and symptoms?

A. It's certainly one of the confounds that I discussed a little bit in my report. I mean if you go back in Mr. Desmond's history, although there's some unanswered questions about some of his early life experiences, there wasn't any information that I had available to me that suggested that, for example, pre-deployment that he had paranoid personality traits. He was not ... I had no information that suggested that he was a suspicious man of any nature, that sort of thing.

There were issues early on, of course, with his marriage but that's a separate issue in some ways. And with the mood lability, certainly that again was not recognized pre-deployment. He was described as a happy-go-lucky guy. But when he comes back, all of those features become more prominent over time. So it creates some difficulties in separating out whether those are personality traits by which would mean enduring personality features that the person has over the course of their lifetime or whether those are, in some way, part and parcel of the ... with both of those, really, whether those are part and parcel of some interplay between the post-traumatic stress disorder symptoms and some of the ongoing marital difficulties that Mr. Desmond had.

Q. These two forms of traits, paranoid personality

traits, borderline personality traits, and how they're exhibited, I guess, through Lionel Desmond, would you say that they appear to be primarily in the context of Shanna Desmond and beliefs he has about her and thoughts about her?

A. Certainly, they seem to predominate in the conversation. I mean much of the difficulties that Mr. Desmond had as it relates to both of those features were set in the context of that marital relationship, to the point where he becomes very mistrusting of his wife and what her motives were, and you hear phrases like, "trying to ruin me financially" and those sorts of terms. So that's a predominant feature that I don't see in his discussions about things about other people. Although as we talked about people yesterday, there were some concerns after he returns from deployment about workplace issues and the potential for harassment of a racial nature which certainly could have been present there.

(10:20)

Q. What about his sort of persistent beliefs that she may be having an affair with someone else?

A. Well, that would certainly be part of a paranoid personality trait, a picture you have suspicions and misgivings about people in your environment. And certainly as the most

central person in his world, in some ways, that would extend to her, as well.

Q. And we know that he disclosed even at Ste. Anne's to a professional that if she didn't confirm or profess her love for me, it confirms that ... about renewing ... he wanted to renew their vows. And if she didn't sort of profess her love in that way, it was confirmation in his mind that she was taking advantage of him financially. Is that an example of what you're describing as sort of paranoid or borderline personality traits?

A. In some ways, it's a combination of both. So the paranoia element in that would be that if you don't profess your love for me in a specific way, that means that your love is not true or that you're ... even moreso, you're actively working against me in the sense of financially ruining me. The emotional dyscontrol that would come along with that, the degree of upset that that would cause would be in keeping with a borderline style of presentation.

Q. And as a forensic psychiatrist with an expertise in evaluating risk, which is tied to mental health disorders in psychological profiles, these prominent features of borderline personality traits and mixed personality traits that we've seen exist very sort of early on and at least in a year leading up to

the tragedy. What, if anything, does that tell you about the risk that Lionel Desmond may have posed to Shanna Desmond and Aaliyah and his mother, I guess, in the home?

A. When you look at the literature on violence and mental disorders, in general, I mean of course the literature would show that most individuals with mental health disorders are not particularly violent, no more violent than the general population. But there are some exceptions to that and one of those is individuals with personality disorders and, particularly, antisocial personality disorders which Mr. Desmond did not have. And individuals with borderline personality disorders have higher rates of violence as well as higher rates of suicide, as well. So those sorts of features of emotional lability and instability would be issues of a concern for management of that person on a go-forward basis.

Q. And so had you ... I guess I'll put to you in a situation where had you been a treating psychiatrist of Lionel Desmond in August of 2016 and you were aware of the information about the recurring homicidal thoughts on a daily basis and you were aware of the paranoid personality traits, borderline personality traits and how they interconnected with Shanna Desmond, would you have sort of flagged in any way or had

concerns about risk for suicide or violence directed towards the family?

A. Well, given that he was regularly voicing those kind of concerns, yes, I mean I would have some concern about it. The concerns would usually predominate on the suicide side because that's the more common outcome for these sorts of scenarios. But given that he had voiced some of these homicidal thoughts as well as sort of the ongoing sort of concerns that he had about his wife, that would be an area of concern as well for potential risk.

Q. I guess at this point, Doctor, I'll ask you sort of a tricky question but it's a theme that's come up with the healthcare professionals and it's a theme which is professional and patient confidentiality; you know, at what point does a disclosure on a client's behalf trigger a discussion that involves somebody who may be at risk.

So, for example, we have various clinicians and doctors saying Lionel Desmond has indicated homicidal thoughts as it relates to his wife. He's talked about homicidal dreams. He's expressed sort of repeated themes of jealousy towards his wife. At various points, he's consented to contacting Shanna Desmond, allowing his practitioner to contact Shanna Desmond, and at

other times he's pulled it back as well. He did that with Dr. Murgatroyd on one occasion.

Is there anywhere that you can see, in review, that would prompt a frank discussion with Shanna Desmond about risk or an opportunity to discuss with Shanna Desmond a risk that Lionel Desmond may have posed to her and her daughter? I know the question was sort of jumbled there and I can go back and break it down.

A. No. That's okay. And you're right, it's a tricky question because there's no really straightforward answer to the problem, of course. Right? So, on the one hand, we have a tradition in mental health and certainly more broadly in society of patient autonomy. So the patient is, in many ways, considered to be the person in charge of their care. And so we're very cognizant of the idea that we have to respect their wishes in terms of who they want involved in their care.

We certainly would encourage the person to develop what we would call a circle of care. So that would normally include spouses and family members and so on and so forth, meaning that we could communicate freely amongst them in terms of coordinating and managing their care. And so in that context, it would be useful to ... had Mr. Desmond been able to agree to

that, to have those conversations with the various individuals which would have included his wife, but may have included other family members as well to sort of pull together some of that other information that we've had some discussion about from his past.

But the problem is is that the respect for autonomy is often considered to be paramount, so in the absence of an immediate sense of imminent crisis you're bound to respect that.

So in this case with Mr. Desmond, despite the fact that he had repeatedly talked about suicidal and homicidal ideation, he'd also reportedly indicated, Yes, but I wouldn't do it, which, you know, we know ultimately wasn't the case.

So in that sense, the clinician is then left struggling with, you know, Is this now a case of imminence where I can now disregard or set aside the patient's right for privacy by contacting a third party, right? So there's no easy answer to that question. But those are the kind of considerations that you would put into place.

Q. For example, we know at Ste. Anne's that he consented to the phone call which was Shanna Desmond. And the professionals there indicated that during the phone call they were hollering at each other. It was very sort of a

dysfunctional phone call. Are you familiar with that?

A. Yes.

Q. And is that sort of an opportunity at that point for a psychiatrist or professional to sort of have a side conversation with Shanna Desmond and discuss, Okay, clearly, things aren't going well and you ought to be aware of sort of concerns. Is that a possible opening?

A. It would be although, of course, what would be required at that point in time is that unless it was felt that Mr. Desmond was not capable of making his own decisions in that regard that if he said, I'm done talking and you can't talk with her, then the clinician would have no choice but to, for example, end that phone call.

Q. And we know from the records that there was only one occasion that Lionel Desmond, in fact, did that and that was with Dr. Murgatroyd. At one point, he had revoked the consent. But by all accounts, Lionel Desmond was giving consent to many practitioners to contact and involve Shanna Desmond. And in a situation like that, is there an opportunity for the clinician or professional psychiatrist to have a side conversation with her about risk?

A. Yes. Certainly in my forensic work, for example, when

I do court-ordered assessments, it would not be uncommon that I would contact a family member or something like that to obtain collateral information about the person, for example. So that's a common process that we would use.

(10:30)

Q. And, Doctor, I want to turn to the aspect of, just briefly, the concept of what Dr. Slayter referred to as borderline delusions. And he did certainly testify that Lionel Desmond did not have actual delusions, but he talked about his sort of deep-rooted paranoid thought and he referred to them as borderline delusions. Would you agree with Dr. Slayter's assessment?

A. I would certainly agree with Dr. Slayter's idea that they weren't fully formed delusions. The term we would often use is "overvalued ideas". So the notion that something may be happening, but it's not quite held with delusional intensity, meaning that it's not held with 100 percent certainty by the individual, which is the hallmark of a delusion.

Q. I'm going to ask you a question. At page 17 of your report, right at the very top, you reported:

> The information available to me would indicate that over time Mr. Desmond became

increasingly preoccupied with concerns about the potential infidelity of his wife and increasingly concerned that she could not be trusted and indeed was taking advantage of him. In my opinion, it could not be said that these were held with delusional intensity. Although Mr. Desmond at times appeared to be greatly distressed by these ideas, they do not have the hallmark of delusion in that they were not held with 100 percent certainty by Mr. Desmond. Even if they had held with delusional intensity, that would not have, in my opinion, created a scenario in which, had he survived, the actions of Mr. Desmond could have, for example, led to a successful defence of not criminally responsible.

So, with that paragraph, there's a number of things I'd like to review here. I guess, first, is, in your opinion, was Lionel Desmond's diagnosis such that his actions of killing himself and family were such that he was incapable of appreciating the nature and quality of his acts or knowing that

they were morally wrong? That's the test for NCR. So, in your opinion, is there anything there to suggest that had Lionel Desmond survived, he would have been not criminally responsible on behalf of mental disorder?

A. Not with the information that I have available to me, no.

Q. Is it your opinion that Lionel Desmond's actions were such that he knew what he was doing was wrong or morally wrong?

A. I think Mr. Desmond was a reasonably intelligent individual and, in the actions that he undertook, he would've been aware that those actions were both morally and legally wrong, yes.

Q. And is it your opinion that he understood the nature and quality of his acts which is taking the gun and doing what he did with the firearm?

A. Mr. Desmond was, of course, a rifleman in the services, so he was familiar with firearms. He had purchased a firearm on the same day as this tragedy occurred, so he was familiar with how weapons were used and he utilized the weapon in the events of January the 3rd, so I don't think it would be possible to conclude anything other than that he was aware of the nature and quality of his actions.

Q. I'm not going to go further into that; however, I want to ask you. You made a point of sort of separating out the idea that Lionel Desmond had persistent and consistent beliefs and patterns of thoughts as it related to Shanna Desmond. And you indicated that they didn't rise to what were held as delusions or delusional intensity.

However, I want to ask you, in your opinion, did his persistent thought process and views, as applied to Shanna Desmond, factor in this question of his intent to kill her and perhaps his daughter, Aaliyah, and mother on January 3rd?

A. I think when you look at all the information taken together and the acceleration, if you want to call it that, of his preoccupation with his partner over time, and then his being placed in his home community where he's attempting to resettle in and, as we talked yesterday, sort of get his care coordinated, that plays a significant role in the events that happened. And then, as is sometimes the case with these kind of tragedies, there's a sentinel event which, in this case, appeared to be ... in some ways, it was twofold. There was a relatively minor motor vehicle accident on New Year's Eve, and then there was, in the documentation, discussion about how upset Mr. Desmond became over that matter. And then that was followed

by what appeared to be perhaps the final sort of decision of Ms. Desmond to end the marriage, which was something that Mr. Desmond talked about to his therapist, I think, on the 3rd of January.

So those are all the events that may have been the spark that lit the fire, so-to-speak, in terms of the events that occurred on that day.

Q. And towards the end, I'm going to sort of take you through those sequence of events and get your thoughts sort of sequentially as it relates to them. This is more generally, I'm trying to establish whether or not there was any link in between those persistent and chronic, as you described, thoughts relating to Shanna Desmond and his ultimate intent.

The other question I had is, page 18 of your report, you talk about the incident which was the choking incident. Are you familiar with that sequence, Doctor, when Lionel Desmond is sleeping and he wakes in the middle of the night?

A. Yes, that was part of the information that was in the affidavit of Ms. Theresa Borden and it was something that she had also shared with me in my conversation with her.

Q. What, if any, sort of analysis or opinions do you have with respect to that scenario where Lionel Desmond wakes in the

middle of the night and he's choking Shanna Desmond? And I'm mindful of the fact that it was somewhat in the past.

A. Right.

Q. And you're looking at this quite removed.

A. Well, it raises a general concept and understanding of what we call "flashbacks" in the area of post-traumatic stress disorder. And, in my experience, there's often some conceptual confusion about what flashbacks are and what flashbacks aren't. So one of the symptoms of PTSD, as we've discussed, are intrusive thoughts. And people often refer to intrusive thoughts as "flashbacks", but intrusive thoughts are just that; they're not flashbacks. Flashbacks are a dissociative event in which the person feels and acts as though they were in the place where the trauma occurred. So, in that sense, it's a relatively, usually truncated in time kind of experience which I would no doubt imagine is quite distressing to the person.

So that particular event that's described, with Mr. Desmond choking his wife, whether that was a flashback or whether that was a nightmare that he was responding to in some fashion is hard to know but, in my report, as you can see, I've gone on to look at that in the broader context of whether there was evidence to suggest that some sort of flashback or dissociative

event was active around the time of the tragedy itself.

Q. Are you able to comment as to how something like this plays in a sort of a risk analysis for future violence?

A. That's a good question. I don't have any definitive information about it. The research that I did at the time suggested that flashbacks, in and of themselves, are not really associated with risk for violence; they're usually, as I noted in my report from one of the studies, that it was more related to sort of a defensive maneuver, so-to-speak, so high "huddle in place" or, you know, sort of protect oneself because the trauma is often sort of directed towards you, not directed away from you.

(10:40)

Q. And sort of mindful of the information that you were provided, are you able to definitively say that this occurrence where they're in bed, he awakes, and he's choking Shanna Desmond, are you able to say with any level of confidence that this was a flashback related to PTSD symptoms? Are you able to sort of say one way or the other?

A. No. It could've been a flashback or it could've been sort of just awakening from a nightmare, for example, and responding to that.

Q. And, I guess, if it's not a flashback and it's awake ... I know these are very sort of abstract questions in many ways, but if it's not a flashback and it's awakening from a nightmare and you're choking your wife, what sort of sense do you make out of that, clinically?

A. Well, if I were a clinician dealing with it at the time, my initial role, I think, would be to try to help diminish the frequency and severity of the nightmares because whatever was going on was related to that sleep state, so dealing with that would've been my primary priority.

Q. Okay. I'm going to ask you a bit about ... and we're going to revisit that topic about intent. But, for now, I'd like to ask you a little bit about suicide and suicide risk assessment. So, at page 19 of your report, you referred to Lionel Desmond's suicidal ideation as "chronic suicide ideation". What did you mean by qualifying it as "chronic"?

A. His suicidal ideation was chronic in the sense that it was a constant theme in his presentation to others, so it was a constant idea that Mr. Desmond had over time. So, often in psychiatry, we often think of suicidal ideation as acute, chronic, or sometimes "acute on chronic", if I could use that phrase. So an individual that may have acute suicidal ideation

might be responding to an immediate stressor that they've had some exposure to, but, historically, don't have sort of chronic suicidal ideas. So in that kind of scenario, your focus is on dealing with sort of the acute stressor that the person has, right? That may or may not, in the context of an assessment, lead to, for example, an individual being brought into hospital, in the sense that I would see somebody in the emergency department to do that.

Somebody with a chronic suicidal ideation is an individual who, either by dint of the illness that they have or, for example, by a dint of their personality - which is quite common, as we've talked about, with individuals with borderline personality disorder have chronic suicidal ideation - those individuals, although they're at increased risk of suicide overall because of the chronicity of that suicidal ideation, we would not generally, for an individual with chronic suicidal ideas, bring them into hospital because it's not been demonstrated to be particularly useful and, in some instances, coming into hospital can actually be counterproductive. So we tend to try to manage those cases in like having the person connected to sort of a continuing therapy.

And then, of course, you have an "acute on chronic"

situation where somebody may have chronic suicidal ideation and then has a new stressor that sort of decompensates them to some degree because of that, and so the severity of their suicidal ideation is exacerbated at that point.

Q. I'd like to get your sort of thoughts as it relates to Lionel Desmond in particular. So there's a long-standing history of documentation that led you to believe, you know, he had chronic suicidal ideation. You commented before about significant stressors he had which were his life in many respects. Is there any heightened risk to Lionel Desmond in the fact that he has chronic suicidal ideation coupled with many stressors that are ongoing at the time?

A. It would certainly lend itself to sort of your assessment of risk and sort of your plans for risk management which are the essential factors that you're trying to do when you're dealing with an individual with ongoing suicidal ideation.

Q. He had a documented history that he would report suicidal ideation, but then when he was asked whether he had an intent or plan, he would indicate that he did not. From your perspective, how do you go about sort of evaluating whether or not that's sincere in a client or patient, if there's chronic

reports of suicidal ideation, and then when they're asked, Do you have any intent to act upon it, or plan, and the answer is, No?

A. Part of the issue within suicide risk assessment and suicide risk management is, to my mind, I make a distinction between suicide prediction and suicide prevention. So, arguably, everyone's interest, of course, is suicide prevention which is sort of the goal of all clinicians that I would work with.

Part of the difficulty that we have is that, as it relates to suicide prediction, that, although, as we discussed yesterday, we do, on a routine basis, suicide risk assessment instruments, there's no ... I was going to say "infallible", but even general way that you can predict suicide in the sense that because it's such a ... and I talk about it in my report, what I call the "low base rate problem". So suicide has a base rate in the population of about 11 per 100,000 per population per year, which is tragic, but it's still a relatively low, absolute number. So the practical problem is that any suicide risk assessment instrument that you use is quite insensitive and it leads to the risk of what we call a "false positive". So that is predicting somebody will be suicidal when, in fact, they're

not going to be suicidal. And that, in many ways, is a dilemma to a clinician because bringing somebody into hospital, for example, because they have suicidal thoughts, given the false-positive rate is so high that the likelihood is that you run the chance of bringing somebody into hospital who was not going to do anything, and then so you've impeded their autonomy and their freedom in doing that.

So instead of risk prediction, we really talk about risk management. So our focus, really, is trying to characterize people in a more broad sense of being sort of low, moderate, or high risk in terms of their risk for suicide without sort of putting any predictive number on it because of the reasons that I've said. And then you try to create sort of a suicide prevention plan that sort of helps mitigate whatever that risk component is.

So those are the factors that go into thinking about this situation.

Q. So, I guess, if someone has sort of chronic suicidal ideation and then a consistent, I don't have intent; I don't have any plan, does that necessarily mean that there's a diminished risk when they follow up with that answer?

A. No, it wouldn't indicate that there's a diminished

risk. As I've said, it would mean that you're still going to have difficulties predicting whether that risk will come to fruition, but it would suggest that you would want to have as robust a suicide prevention plan available for that person as possible.

Q. And we'll get into that. So when somebody answers, I don't have a plan and I don't have intent, how valuable or how much merit does that sort of answer have to you as a forensic psychiatrist when you're doing your assessment of risk? They report suicidal ideation ...

A. Yeah.

Q. Then they tell you, No. You ask them, Are you going to harm anyone? No. Are you going to harm yourself? No. How much value do you put in that self-reporting?

(10:50)

A. Well, I don't normally take it at face value. I might ask a few probes around it. I might say, Okay, well, how would I know if that's getting worse? What would you tell me? How would you feel? What would that look like? What could you do? You know, those sort of, just a more sort of broader discussion around it to either sort of help me buttress their response as being reliable or sort of raise further concerns about it.

Q. In your global assessment of this case that is Lionel Desmond and the many interactions he had with health care practitioners, psychiatrists, psychologists - whether it was therapist, Catherine Chambers, whether it was Dr. Rahman in the ER - did you see any sort of opportunities for a perhaps different approach to suicide prevention or suicide risk assessment?

A. I think certainly with respect to the issue of suicide prevention, and I think we'd had some discussion of this yesterday as well that Mr. Desmond would've benefitted from a more robust suicide prevention plan in the sense of a plan that had sort of a number of specific ideas or things that he could do that, should his suicidal ideation reach a point where he was having trouble coping with it, that he had a number of mechanisms that he could utilize to try to mitigate that risk over time. So that would be certainly one approach to the issue.

Q. If we look to Exhibit 330 ...

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

MR. RUSSELL: Oh sorry, Your Honour.

THE COURT: So part of a suicide prevention plan, would it likely include something like asking, in this case, Cpl.

Desmond, whether or not he had firearms, if he had access to firearms or he had a firearms license so that he could buy a gun, and maybe suggest that he give up his license? Would that be a reasonable thing to incorporate into it?

A. Yeah, certainly, part of a suicide risk assessment generally would be an exploration of, you know, If you've got suicidal ideas, do you have the means to an ends to accomplish that? So that could include weapons of various sorts - knives and so on and so forth - but, certainly, firearms is a common one that we would ask for, whether they have either firearms or access to firearms. And then sometimes we would go on to say, Well, could I ... And this is usually in the context of a more continuing relationship with an individual, you could say, Gee, I think it would probably be smart if you didn't have the firearms. Could I suggest that you do that? Could we make a call together for, you know, to sort of get rid of them, get the firearms out of the house? Or that sort of thing.

THE COURT: One of the other issues, I guess, is that not only do you ... the firearm can go out the door, but as long as you're still in possession of a license and you have the ability to purchase another firearm, you ...

A. You don't want it back, yes.

THE COURT: So I would think that the discussion would include not only, you know, maybe giving your firearms to somebody else, but also giving up your license, and if in no other way than to somebody else for safekeeping because without the license, you can't purchase firearms. That's one of the things that we really have to ... that I'm going to look at is that whole question of, you know, whether he should've had the ability to purchase a firearm, which really needs means his license.

Given all that you know about Cpl. Desmond, and if you take him right up until just before he walks into the gun shop to buy the firearm that afternoon, all right, and I appreciate this is the value of going over it and collecting all of that information and giving it to one individual. If you had all that information available to you and you learned that he had gone into a shop to purchase a firearm that afternoon, would that have signaled anything to you? Would that have caused you to have any kind of immediate reaction to that in terms of risk?

A. Oh, it would certainly heighten my concerns about potential risk, yes.

THE COURT: Yeah. I know I asked you the question and the answer is pretty obvious, I think.

All right, thank you. Sorry, Mr. Russell, go ahead.

MR. RUSSELL: Yes, Your Honour. My intention was to sort of finish this sort of theme with suicide risk and then perhaps a morning break?

THE COURT: Sure, thank you.

EXHIBIT P-000330 - FOOTNOTE 2 - THERIAULT - SUICIDE RISK

MR. RUSSELL: Doctor, Exhibit 330. This was referenced in your materials. It said, "Suicide Risk Assessment and Prevention - A Systematic Review Focusing on Veterans".

Doctor, if you could tell us, is there a higher suicide rate in veteran populations than in the general population?

A. It's a curious history, actually. It used to be that the suicide rate in veterans was less than in the general population but, in recent years, it's exceeded the general population. And from about 2008 onwards, if I remember my details right, the suicide rate in veterans has gone up sort of year over year, so it now exceeds that in the general population.

Q. Are you able to comment as to how it compares to the average rate?

A. I couldn't really say to what percentage it's over and above the average rate, but just that it is, really.

Q. And is this valuable information? I mean each piece of information is - collectively, together, you have to look at everything - but is this valuable information to, say, a clinician or a physician that's assessing a military veteran, the high rates of suicide within veterans?

A. It would be useful in sort of helping create that suicide risk management plan that we've talked about, (1) because we know that the rate is higher in veteran populations than it is in civilian populations; and also because we know that rates for suicide in individuals with PTSD is significant as well. So those are both sort of environmental factors. If you think about his being a veteran as well as sort of clinical factors, that increases risk for suicide.

Q. Are you familiar with the various suicide risk assessment tools used by clinicians in Nova Scotia?

A. I'm certainly familiar with the one that we use most often, which is, we call it the "SRAI" - the Suicide Risk Assessment Instrument - which is the standard one that we use for assessments and on a periodic basis within the Nova Scotia Health Authority.

Q. And, in your opinion, how valuable is such a tool and how reliable is it?

A. It's valuable in that I think it helps an individual clinician sort of in two ways. I think of it as sort of a tool that, when done periodically, helps you sort of assess whether a person's trajectory is improving or worsening in terms of their suicidal ideation. So that's one purpose of it.

It's useful in highlighting some of the issues that you might want to put into a suicide prevention plan because there are different items that you would score. So, in that respect, it's useful. As I've discussed, it has quite significant limitations and it's being used as actually a predictive instrument in terms of predicting what will happen because of the difficulties with the false positive rate and the relatively low absolute risk of suicide.

So I think of it as more an instrument that we use to think about what's the person's relative risk of suicide compared to other individuals versus sort of could I use this as a way to predict that this person will do this within a particular timeframe, which is what we do with some of our other violent risk assessment instruments.

Q. Collectively, in your opinion and through the lens of what you've seen - this tragedy and what led to this tragedy - is there room for, I guess, this province to sort of maybe take

a deep dive and re-evaluation into how we measure suicide risk and how we formulate suicide risk prevention strategies?

A. I mean I think I would ... my view would be that I would really focus on that latter point, that I think that ... I mean I know that within our Mental Health and Addictions program that every patient is supposed to have a treatment plan; that's part of our processes, so part of that treatment plan could include sort of a robust suicide risk assessment management plan, for example. So that would be one way to approach that, I think.

(11:00)

Q. So knowing kind of what you know through the lens of this, is it your opinion that what could be visited here is sort of a suicide risk prevention plan structure and how those are administered throughout situations such as this?

A. Yeah, that would be an idea, and you could look at whether that would be different with different populations of individuals, whether that would be different, for example, with people with post-traumatic stress disorder, or veterans, or people with other sort of disorders that historically have a high rate of a suicide risk. So you could sort of, you could develop a suicide risk management plan that's more nimble, if I

could use that word.

Q. I guess it was a comment that I heard that said, We like to say that we're all the same but, in fact, we're all different. And I'm thinking of sort of Lionel Desmond. He's a veteran, he's part of an African Nova Scotian community that had unique sort of aspects to his psychological profile. Is there value in sort of re-evaluating the suicide risk assessment prevention tools as it relates to those different, distinct populations, where possible?

A. Yeah, I think that's a good point. I mean I think that, increasingly, we are concerned about issues related to cultural competence and cultural understanding of different populations. And so, inasmuch as different populations may have different risk factors or different sort of responses to different stressors, then understanding that in some way might be a useful tool to have in terms of both general treatment, as well as a more specific suicide risk management plan.

Q. I take it, in your career, you've been involved in many suicide risk prevention plans.

A. Yes.

Q. For many patients?

A. I have.

Q. And can you give us just a general estimate or qualification of how many you might've been involved in?

A. Hard to say. I mean hundreds, I would say, because almost anybody that leaves our forensic site, we would develop certainly a violent risk management plan but, often, that would include a suicide risk management plan as well.

Q. And in Lionel Desmond's set of circumstances, was there anything unique to him that would suggest there was a need for a more robust plan and a different plan?

A. Well, I think that, from the conversations that we've had so far, that Mr. Desmond needed a suicidal risk management plan from very early on in his care because he had, as we've talked about, chronic suicidal ideation. And that plan needs to morph and change over time depending on the circumstances that Mr. Desmond found himself in over time, so what it would look like when he was a serving member of the Forces might be different than what it would like when he was a veteran, and then again would look different than when he returns to Nova Scotia from where he had been residing before, because some of the factors at play were different in each of those circumstances.

Q. For example, we've heard throughout testimony that

when it comes to, say, a psychiatrist or a professional, that suicide risk assessment or risk analysis is very professional judgement- driven. In your report, you talked a little bit about the different approaches to predicting suicide and violence. Do you have any sort of concerns about that sort of, It's a professional judgement approach to risk prevention or risk analysis?

A. The general question gets into the overall concept of how we conceptualize risk assessment. So, just broadly, perhaps as much for my education as for the Court's, so we consider risk assessments in three different areas really. So we have what we would call "clinical judgement", right? Unaided clinical judgement. So that's the idea that you predict the risk for an event occurring and I use my clinical judgement to do that, right? So that's one.

The other one is sort of an actuarial approach which I'm used to using within the forensic realm because that's been shown to have some predictive validity. The actuarial approach is when you use known risk factors for an outcome of interest, say, violence in this particular sort of example - and you apply a listing of those factors and they're all weighted in a particular way to give you an estimate of the probability that

such an event will occur.

And then the third one is what we call "structured clinical judgement".

So each of them have their pros and cons. The most unreliable one, of course, is standard clinical judgement because there are some clinicians that might honestly be very good at it, but there are other clinicians that it's kind of shooting in the dark and if you take it broadly, then a clinician's ability to predict an outcome of interest, whether that's suicide or violence, is really no better than chance alone. So we don't tend to utilize those, at least in the forensic enterprise.

The actuarial risk assessment instruments, they have a certain amount of validity, but their drawback, at least in my view, is that they can't deal with variations of what we call "dynamic risk factors". So they're all based on just static risk factors that are unchangeable; so, inasmuch as a person's life situation may change - and so that invokes dynamic risk factors -it can't take those into account.

And then the third is the structured clinical judgement which is a process that's become more and more the norm in sort of risk management areas, and that uses ... it's an assessment

of risk factors that are known to be associated with the outcome of interest, whether that's suicide or homicide or violence of another sort.

And then you do an analysis of all those different risk factors and then you categorize the person generally into different domains, as we've talked a little bit about earlier in terms of suicide - sort of low, moderate, or high - and, in that sense, it's not ... again, it's speaking to relative risk; it's not speaking to absolute risk. So it's sort of, This person is relatively at more risk than that person given the same sort of set of characteristics.

Q. Outside of the forensic world in Nova Scotia, do you have any sense as to what approach seems to be the most predominant approach? You indicated that clinical judgement is no better than chance, in your opinion, and you talked about actuarial, and then you talked about the third category which is the structured clinical judgement approach. Do you know what is commonly used in sort of hospitals in Nova Scotia,\ or practices within therapists' offices in Nova Scotia?

A. Well, inasmuch as we use the SRAI on a regular basis, that's an attempt towards moving towards more of a structured clinical judgement kind of process, although it's not as

rigorous in the sense that I'm used to using some of the ones that I'm familiar with where you would weight each of the different items; although, that is a part of that process as well. So we're trying to move towards more of a structured clinical judgement kind of approach.

Q. Is that a conversation that's worth sort of having in that in Nova Scotia, perhaps, their health care professionals may need to re-evaluate the model that they're using and perhaps shift to a more actuarial model and a more structured clinical judgement approach?

A. I certainly think that a move towards more of a structured clinical judgement approach would be useful. The actuarial model will fail on the basis, really, of the relative rarity of the events that we're talking about. So, with an event like suicide, given it's low absolute rate, an actuarial model would have difficulty overcoming that burden.

Just to help clarify that; for example, so I commonly use an instrument called the "VRAG" - the Violent Risk Assessment Guide - which is an actuarial measure that is meant to predict violence in an individual, but the Violent Risk Assessment Guide requires that the person has already been violent, and has been violent, and has been adjudicated to be violent, because the

problem is is that the absolute risk for violence, in and of itself, is low enough that if you just tried to predict who is going to be violent from a group of a hundred people who've never been violent before, it's very difficult to do, but if you are trying to predict who will be violent again after they've already been violent, we know that about 30 percent of people that have been violent in the past will be violent in the future. So that increases what we call the "base rate" to one where it's much easier to do a predictability sort of analysis using an actuarial method.

(11:10)

Q. Are you familiar with whether any tools could have been used to predict Lionel Desmond's rate of violence, whether it was when he was meeting with Catherine Chambers; whether or not he was meeting with a clinician at Ste. Anne's; or even Dr. Rahman in the ER; whether there are any sort of separate tools or instruments like the VRAG, but would apply to someone maybe without a documented criminal history, I guess?

A. There's none that I know of, I don't think. I mean I know that we would ... you can ... and that information can sometimes be difficult to get because, on the one hand, you have official records of violence, for example, that you can get

through the court system, which is normally what I get within the forensic realm. And then you have the self-report of a person which may or may not be accurate in terms of their own self-reports of violence. So it's another area where it's complicated to get sort of a solid understanding of what any pre-existing history of violence may or may not be, but it certainly would be an area that you could explore with an individual.

Q. And, I guess, back to what we anticipate Dr. Jaffe's evidence to sort of touch upon is that there is sort of suicide risk and his diagnosis, but then there's also domestic violence/intimate partner violence risk, and which involves risk of violence. Do you see room for Nova Scotia, whether it's a clinician's office, a family practitioner's office, or the ER, to move to a set of tools and instruments - actuarial-based, if possible - that specifically focus on risk for violence/intimate partner violence when there are some sort of flags to suggest that it may be an issue?

A. Well, it's certainly an area of exploration. Currently, I know that within the medical school that the medical students get a fair amount of exposure to issues related to domestic violence. That's part of their Pro Comp course that

I'm involved in. So they get an understanding of the different ways that domestic violence can sort of demonstrate itself and they're made aware of some of the potential sort of reasons why individuals in such situations are hesitant or reluctant to leave or share information, and all that kind of information.

All trainees now would be trained in the context of, say, becoming a family practitioner, to routinely ask those kind of questions of individuals that come into their office; and that's even if there aren't any flags, they will routinely ask whether there are those kind of situations.

Q. Would you agree that awareness is one thing - much like today, I have to be aware of the general areas that I have to ask you - but having prompts and sort of knowing what specific questions to ask and perhaps document, which can go in a file and move forward with the patient, do you think there's separate value in having structured prompts for clinicians to use and structured things to be documented that travel with the file?

So, in Mr. Desmond's case, he travels from one clinician to the next, but his record documents a history of suicidal or homicidal thoughts as it relates to his wife, and concerns as it relates to his home life. Do you see value in such a concept?

A. I do in the sense that ... I'm aware of a couple of instruments that I sometimes use. So I'm sure the Inquiry would be familiar with the "ODARA" which is an instrument that police commonly use. And another one that I've used in the past is called a "DVRAG" which is Domestic Violence Risk Assessment Guide, which is an actuarial instrument that's similar to the VRAG.

So those are, again, sort of actuarial attempts to try to sort of highlight, you know, potential risk for things. But in a more clinical vein, you could potentially try to translate some of that information into sort of clinical questions that you could ask somebody that's both respectful of them, but sort of tries to elicit that information at the same time. So that's a possibility certainly.

Q. And is that something worth exploring?

A. I think it could be, yes.

Q. And finally, Doctor, you're familiar with the dynamic which was Catherine Chambers, on January 3rd?

A. Yes.

Q. Her interaction with Lionel Desmond? And, in particular, at page 20 of your report, you had comments with respect to she had a verbal contract with him, that in a moment

of continued sort of crisis or concern, that he verbally contracted with her to go to the hospital. And we got a sense that that was something that's very frequently employed by various clinicians. What are your expert views on that?

A. Of course you're right. It is commonly a mechanism used by most clinicians as a way to try to sort of encourage an individual to sort of "push the pause button", so to speak. That is, you know, if they're in crisis, to stop and sort of make some sort of other choice. But the literature on that is just a simple sort of, you know, Will you contract with me not to do anything; and, if you do, will you go to the emergency room? Yes.

The information on that would suggest that it's not a particularly effective tool because, of course, unfortunately, situations can change, and then once a situation has changed, the dynamics of it might be such that the person's ability to sort of be forward-thinking enough to sort of say, Well, I need to sort of do this, it sort of goes out the window.

So, increasingly, what would be useful to do is to try to put not just a single mechanism in place, but sort of a number of those mechanisms in place that sort of increase the probability that there'll be a gap between when a crisis

strikes, the impulse to do something occurs, and your planning or intention to carry it out. So, in that sense, as I noted in the report, there are some tools that attempt to be more robust by indicating, Well, these are the things that I agree to do and, you know, this is how I contact this person; this is what I would do in this situation. And to try to sort of develop sort of a more robust crisis management plan, so to speak.

Q. And I know I keep teasing at a break, and that is definitely the final area of suicide risk that I wanted you to comment on. So, I guess, can you quantify how effective and reliable of a prevention strategy is a verbal contract to go to the hospital or seek treatment?

A. In and of itself, not very, I don't think. I mean it might be more effective if you - and, here, I'm just thinking more as a clinician than anything else - it might be more effective if you had an enduring rapport with an individual over a period of time where you had built that level of trust that you and the client both have a sense that that's something that you could enact in the moment of a crisis. But, other than that, it's not particularly useful, I don't think.

EXHIBIT P-000331 - FOOTNOTE 3 - THERIAULT - CH. 5 - 2019 BOOK - VETERAN PSYCHIATRY IN THE US

Q. And in terms of more robust strategies, Exhibit 331, and perhaps page 10.

Perhaps, Your Honour, this would be a time to take a break while we're loading it up.

THE CLERK: There seems to be a problem.

THE COURT: All right. We'll take the morning break, 15 minutes, and try and come back about 25 to the hour then, please?

MR. RUSSELL: Thank you.

COURT RECESSED (11:20 hrs)

COURT RESUMED (11:40 hrs)

THE COURT: Thank you. Did you find what you were looking for, Mr. Russell?

MR. RUSSELL: Yes, it's Exhibit 331, page 10.

THE COURT: Thank you.

MR. RUSSELL: So, Dr. Theriault, where we left off this was a footnote in your report, so I'm assuming you're familiar with the document?

A. Yes.

Q. And, Doctor, we talked about sort of a move between sort of that contract, that verbal contract to seek out resources and move to more of a reliable, preventative strategy.

And in your report you referenced a Stanley and Brown (SPI) Safety Plan Intervention that you came across. I wonder if you could explain to the Court what is a Stanley and Brown SPI or Safety Plan Intervention?

A. It's really an attempt to do that which we were just discussing, which is instead of simply a verbal contract with somebody to, at a moment of crisis do what they had agreed to do in that moment of crisis, to put more concrete measures in place so that the person at least has the opportunity to consider and hopefully utilize some of those measures before acting on their ideas that come out of that crisis.

So it's an attempt ... it's usually ... it's meant to be done in a collaborative fashion, so it's not something that you would do as a once-off thing, but it would be meant to be done in collaboration with the client and then ideally in collaboration with those people that might form part of that support network or the crisis list that the individual has.

Q. And the Stanley Brown, is it specific to, I guess, a veteran population as a tool?

A. I don't think it's specific to veteran population although it's been used as noted in that text, in a veteran population. If it's of interest to the Inquiry I brought

actually a sample of the format for the Stanley Brown.

Q. Okay, perhaps we'll keep it aside and at the break we'll take a look at it. But you see there's sort of ... if there's room for that Stanley Brown tool to be used in a circumstance such as Lionel Desmond?

A. I think there would be benefit for a tool like that to be used for individuals in their overall treatment plan and, in particular, for identified groups of individuals that might be at higher risk as a way to sort of help build that into their treatment plan as a process for managing with a crisis that may come along.

Q. Okay. If we could look at Exhibit 329 and, in particular, page 22.

THE CLERK: 329?

MR. RUSSELL: Exhibit 329.

THE CLERK: There's only 11 pages on that document.

MR. RUSSELL: Oh, I guess I can navigate it without actually seeing the ... if we could just pull it up without the page number.

EXHIBIT P-000329 - FOOTNOTE 1 - THERIAULT - VIOLENT OFFENDING BY UK MILITARY PERSONNEL DEPLOYED TO IRAQ AND AFGHANISTAN 2017

Doctor, is this what you referred to as **The Lancet Study** in

your report?

A. Yes, that's from **The Lancet**, I believe.

Q. And at page 22 of your report you speak of **The Lancet Study**. What is the sort of ... what did that study actually look into and what's its relevance to the circumstances of Lionel Desmond?

A. Well, it was a study that looked at violent offending in individuals that had come back from war service and this was, in particular, in the context of United Kingdom military personnel. So it was looking at rates of violence of individuals that had been deployed to Iraq or Afghanistan in this particular case.

Q. And I'm wondering if you could tell us generally what ... if they made any sort of associations sort of between subsets of PTSD symptoms in veteran populations at a risk for future offending as it relates to violence?

A. I think they had two main findings. One, of course, which is true across all different populations is that co-occurring substance use disorder is a risk factor for violence, but the other was that PTSD was a risk factor for violence, and in particular the hyperarousal symptoms which, as we've discussed, include anger and irritability and those features

that were risk factors for violence.

Q. And we spoke previously, so in your opinion did Lionel Desmond have those two risk factors that were outlined in this particular report?

A. Well, he'd had ... to speak to the first, he'd had a history of some substance use difficulties primarily with alcohol but at the time of the tragedy that, to the best of my knowledge, wasn't an active ongoing concern. He'd had sort of an up and down course with some of his alcohol use over the years but it wasn't particularly prevalent then. But the post-traumatic stress disorder continued to be sort of an active issue for Mr. Desmond and those hyperarousal features of irritability and anger were an ongoing matter as well at that point in time.

Q. If you take a review, and we talk a lot about risk factors and ones that Lionel Desmond seemed to have for not only suicide but also violence, are you able to offer any opinions or comments on this sort of very loaded question which is, in your global review, did you see as though whether or not this tragedy was predictable in any way?

A. The issue there is, of course, that we've had some discussion about some of the difficulties in predicting an

outcome of interest in any reliable kind of sense simply given the infrequency of some of these events. So in my report I talk a little bit about the frequency of suicide which, as I noted, was about 1 in 10 in a 100,000 or so, it varies from year to year. But sadly enough despite the many years I've been in practice that rate has not really changed very much despite the different kinds of interventions that we've done.

The outcome of interest in this particular case with Mr. Desmond is a case of homicide/suicide and the rates of homicide/suicide are much, much lower, so they're on the order of 2 to 5 per million population per year, so it's a very rare event.

So, again, I think that the area focuses more in, to me, sort of trying to ascertain relative risk rather than absolute risk. So in that sense it's not predictable in any kind of actuarial kind of fashion but the focus is more on identifying risk factors in a relative sense and then sort of applying the principles of treatment and social support and other mechanisms to try to maintain ... what we would call manage that risk within a community setting. So that would be my main focus of my work with that sort of situation.

Q. Do you have any suggestions how the service providers

as they interacted with each other over the course of his totality of his treatment could have perhaps added to what they did to help sort of assess that level of risk?

(11:50)

A. Well, I think if you look at it longitudinally from a clinical perspective I mean certainly attention to some of those hyperarousal symptoms would have been important in managing that risk. Some attention to some of the broader instability of Mr. Desmond's social supports would have been helpful in mitigating that risk because that would have given him a more solid base of support, helping him deal with some of the outstanding fiscal issues, for example, would have been helpful simply because that would relieve one other source of aggravation so to speak, right.

And then of course helping Mr. Desmond come to some sort of resolution with respect to his marital issues would have been a significant factor that would have been helpful in sort of mitigating his risks not only for himself but ultimately for his whole family as occurred.

Q. And mindful that it would be impossible and unfair to single out one provider in one period of time in a small window, very unfair, but collectively, I guess, do you have any comments

about whether this tragedy was preventable in any way as best you can and, if so, in what way?

A. Well, we always think of ... of course any time that we do a suicide risk assessment, for example, we're hoping to prevent the outcome that we're concerned about. So, you know, you have to take into account the fact that given the infrequency of an event like this that it wasn't predictable in any reliable sense, but preventable in the sense that I think of it more in terms of his risk ultimately to do what happened in the end could have been mitigated if he'd had sort of a more consistent continuity of service provision over time, and that that service provision was aware of these different vulnerabilities that Mr. Desmond had and had the opportunity to engage with him and preferably with his spouse as well, around some of the other issues that were at hand, particularly related to the nature of the relationship between him and the stresses that that was causing Mr. Desmond and his family as well, so ...

As well as, we talked about yesterday, the whole concept of the warm handover, so that pertinent information didn't have to wait for periods of time to be received but was done in a "in the moment" fashion so that ongoing care providers were able to have that information at hand to help guide their clinical

treatments going forward with him.

Q. The next area of analysis I'd like to ask you a few questions regarding is is sort of Lionel Desmond's behaviour and then ultimately intent behind the behaviour. I want to put a sequence of events that predate the tragedy by just about a year, so ... which is November 27th, 2015.

So there are three documents there I'd like you to look at. The first is Exhibit 244, page 74. I wonder if we can maybe scroll up, I think I might have gotten the date wrong. Maybe scroll down, November 27th. Yeah, one moment.

So on this particular date, Dr. Theriault, this is a year and about a month and a half ... a year and about five weeks before the tragedy, and this is Lionel Desmond's sequence of interactions he had with care providers, Veterans Affairs and then ultimately the RCMP all on the same date. And I'm going to ask you a series of questions about Lionel Desmond's sort of shifting maybe behaviours throughout the day.

So at 10:30 in the morning Lionel Desmond meets with his psychologist, Dr. Murgatroyd, who had been seeing him for some time. He's described he said "He appears composed once again today despite ongoing stressors." They talked about current plans, lack of support in Antigonish.

He goes through, they're discussing sort of walking away skills, talked about some of his basic needs, and there's nothing sort of ... would you agree there's nothing sort of notable in that sort of report from Dr. Murgatroyd that was indicating that Lionel Desmond was in any state of crisis or need of immediate interventions?

A. I'm just reading through the full script, but no, I would agree, yeah, there's nothing. As he notes: "He appeared composed once again today despite ongoing stressors", so he didn't appear to be in acute crisis at that time.

Q. So from your sort of clinical perspective, and I know you didn't actually meet with him that day, but based on that report is there anything really concerning about an immediate crisis and intervention needed with Lionel Desmond at that point?

A. No. Much of that conversation appears to be focused on supporting Mr. Desmond in some of the skills that he was attempting to impart with him, the walking away skills and those sorts of things that encourage him in activities and good nutrition and that sort of routine kind of a ...

Q. Is there any suggestion of sort of homicidal thought or suicidal ideation?

A. Not in that note, no.

Q. If we could look at Exhibit 292, page 9. If we could scroll down, okay, just up just a little bit. Up a little bit more.

So what you're looking at here, Doctor ... we don't have the exact time but it's certainly ... by the way it reads it's after Lionel Desmond's meeting with Dr. Murgatroyd that morning. This is an entry from Veterans Affairs Canada which is an interaction he has with Ms. Doucette on the same date. It's a phone call between Mr. Desmond and his case manager.

You'll see there: "Client returned writer's call (which is the case manager). He expressed being pleased about finally being assigned a case manager." They discussed his current situation and perhaps next steps to manage the rehabilitation process and he was ... talked about a favourable decision he'd received from Rehab Services.

If we scroll down and then we go to ... if you see that passage under "Screening Comments"?

A. Mm-hmm.

Q. If you could just take a moment and read that, Doctor.

A. Okay.

Q. So is it your understanding, I guess, from reading

that passage that there is some discussion. "It says without being probed Lionel Desmond starts to talk about his family situation, he talks about the instability in the relationship with his living situation back and forth and living in his wife's family's home in Nova Scotia."

Is there anything in there, Doctor, from your assessment that would seem to suggest that he was contemplating suicide or self-harm or there was a risk for either of those two things?

A. Certainly it's not documented that he raised that spontaneously and the documentation is that he assured he is not thinking of suicide or self-harm. So inasmuch as that documentation is accurate I couldn't say that there's anything to suggest that it was an issue for Mr. Desmond at that point.

Q. So we have a situation where he's, in fact, assuring his case manager I'm not thinking of suicide or self-harm. She checks that out and he gives her assurances to the contrary?

A. That's correct.

(12:00)

Q. So if we then finally look at Exhibit 84. And, Doctor, I'm operating on the assumption that you had seen these materials before. I know we provided them to you. If we scroll down and just leave it there.

So, Doctor, this is the interaction with the RCMP from the same date. This is where RCMP are dispatched to his residence in Oromocto where Lionel Desmond has that conversation with Shanna Desmond and she, in turn, is alarmed at suicidal thoughts and alerts the RCMP to go to his residence. Are you familiar with that encounter?

A. Yes.

Q. And that happens at around 10:22 p.m. on the same date.

So on that phone call with Shanna Desmond, he reports that he was ... tell his daughter goodbye. He's going to the garage that's where she knew he kept his firearms. He makes comments that are suicidal in nature and they go to his residence and ultimately take him to the hospital.

Are you familiar with ... do you need more time with that report or are you familiar with it?

A. No, I'm familiar with it. Yeah.

Q. So, Doctor, my purpose of showing that sequence of events to you is I'm trying to get a sense from your perspective of Lionel Desmond's profile in that we have three interactions and the start of the day, the middle of the day and ultimately the end in the evening, would you agree that they seem very

inconsistent with each other?

A. Well, they would certainly suggest that there was a change in Mr. Desmond's presentation between those three points in time, that's true.

Q. What do you think is happening with ... is it typical to see such a change in presentation over the course of almost exactly 12 hours in the same day?

A. We've had some discussion this morning about the issue of borderline personality traits so inasmuch as Mr. Desmond had some borderline personality traits. One of the issues is that individuals with those traits are prone to mood instability, so their mood can change quite rapidly over a relatively brief period of time, often as a result of relatively minor changes in circumstances. So that could be reflective of this situation here, in that he's relatively calm in the morning but by evening he's engaging in a context that's suggestive of suicidal ideation and is of more of an alarming nature.

Q. Would you say in what you know about Lionel Desmond and, in particular, those borderline personality traits, are you surprised to see this? Such a shift in assurances to his case manager: I'm not suicidal. He seems to react fine with Dr. Murgatroyd in the morning and then all of a sudden he's saying

this to his wife causing the RCMP to have an intervention. Are you surprised to see that with Lionel Desmond's profile?

A. Well, I'd like to say I'm surprised but I'm not really surprised in the sense that inasmuch as individuals with that kind of profile with the mood instability that Mr. Desmond had demonstrated that that kind of crisis-driven reaction to events is quite common. So as a clinician I'm not surprised to see somebody go from a relatively controlled state of mind to a much more fragile and emotional state of mind within a matter of hours. So that happens not infrequently.

Q. What, if anything, is that telling you about the reliability of Lionel Desmond's self-reporting to clinicians when he's asked, Do you have suicidal ideations or intent? This sort of scenario, what does that tell you about the reliability of his self-reporting to clinicians?

A. It's an interesting question because one of the difficulties with individuals with borderline personality traits is that frequently when you interact with them and they tell you, I'm not suicidal in the moment that's their truth, in fact, they don't believe that they are suicidal. The problem is is that they can't proactively sort of predict when they will become suicidal or under what circumstances they may become

suicidal.

So in that sense, although the individual may be reliably reporting their mental state at the moment and what they believe to be the case, it can shift dramatically with very little notice.

THE COURT: So I'm just going to ask you a question while I think about it. Would that apply as well for things like drinking behaviour? The reason I ask it is that earlier when it was being discussed, I know that you had said it appeared ... we were talking about alcohol and it appeared to be that maybe in the later days it didn't seem to be as much of an issue. But that was self-reported by Cpl. Desmond.

As I read yesterday the evidence of Cpl. Trotter, who had had a conversation with Cpl. Desmond, and I was just trying to find it now and I may dig out over lunch. And in a conversation with Cpl. Desmond where Cpl. Desmond, I'm paraphrasing, would have been intoxicated and he thought that that was after he'd been released from Ste. Anne's Hospital. But Cpl. Desmond, and even when he was at Ste. Anne's, seemed to present that alcohol was no longer an issue and he wasn't drinking. But now we've got Cpl. Trotter whose recollection was that that had occurred ... this kind of heavy bout of drinking, he had a conversation

on the phone with him had occurred afterwards.

So would that be ... drinking behaviour, would that be the kind of thing as well that when asked by a clinician, Are you drinking and then in the moment it's not a problem for him but in reality he's still drinking but not telling anyone about it? Is that the same kind of event or is that kind of a different?

A. No. Yeah, my ... both the literature and my experience as a clinician would be that people rarely tell me the truth about their consumption of alcohol or other substances. There's a ...

THE COURT: Okay.

A. ... tendency generally to minimize one's consumption because whether it's out of embarrassment or shame or just don't want to let the doctor know sort of thing. So that's a ... it's always a live issue as to whether people accurately self-report their substance use.

THE COURT: And if ... because I know that when we look at Cpl. Desmond sometimes there might be a tendency to take alcohol abuse kind of out of the equation because of the way he reports it; whereas, as I said, from the evidence of Cpl. Trotter it seemed to me that it may have still been there but well masked by Cpl. Desmond in the discussions he'd had with his

various care providers.

And sometimes I think that it should be given perhaps a little bit more weight in the mixture and it sometimes happens. That's just my observation. If I find that over lunch I may have another discussion with you.

A. Thank you.

THE COURT: Sorry. Thank you, Mr. Russell.

MR. RUSSELL: So, Doctor, obviously we have the benefit of being able to construct something like that in hindsight that pulls three different entities together which, you know, being honest in a practical sense it may not even be doable. But my question is it's one example that what you had talked about highlighted the borderline personality traits, the hyperarousal and the quick fluctuations as to how his mood can change. Is it important somehow for healthcare providers to gather that information and share it amongst each other until they ultimately unfortunately who is sort of left there is a psychiatrist in the ER? Is there a benefit in having that information before that sort of psychiatrist, in fairness to that person?

A. It would always be beneficial to have as much background information as you can readily have available when

you're seeing an individual and particularly in the context of an acute situation like in the emergency room situation, so that would help.

We had some discussion yesterday about how, in practice, difficult that can be across our current health authority simply because of some of the operational sort of issues around that information flow, but yeah, it's useful to know.

I mean most clinicians that deal with anybody with borderline traits would be familiar generally with the idea that the mood still can be a difficult thing to pin down because it's a fluctuating quantity over time so ... But information as to how to manage that or information about under what conditions you might expect exacerbations under would be useful information to have.

(12:10)

Q. And, Doctor, the last sort of area that I want to touch upon is the events the day sort of post-St. Martha's, January 2nd to the tragedy and what is sort of being referred to by His Honour as sort of forward thinking on Lionel Desmond's behalf. There was a document that we prepared, it wasn't entered as an exhibit but rather a sort of summary of the sequence of events if we could bring that up. And, Doctor, you

would have seen all of the reports obviously provided to you, this was simply a summary just to act as an aid, I guess.

THE CLERK: We don't have that document.

MR. RUSSELL: It was the ... well, perhaps, yes. You don't have it? Okay. I guess we don't have it, but, Doctor, I can maybe ... stop me ... I can sort of outline the sequence to you and if at any point ... I can bring it up in separate exhibits which is a little more cumbersome but perhaps ... I guess I'll start this way and if we have to bring up each separate exhibits we'll do so.

THE CLERK: Mr. Russell, we can get it up on display, we just need maybe a minute.

MR. RUSSELL: It might be worthwhile to have it up on display.

THE COURT: We'll take the time and bring it up then. What is it that ... again, what is it that you're looking to have brought up?

MR. RUSSELL: It's the sequence of events that's January 2nd leading up to the tragedy and it's about different things Lionel Desmond did throughout the day that were sort of forward thinking in nature.

THE COURT: Right. Thank you.

MR. RUSSELL: Thank you.

So, Doctor, this is sort of a summary of the various exhibits that you were provided with that span between January 2nd at 11 a.m. when he leaves St. Martha's and ultimately the tragedy which occurs on January 3rd. So generally, I guess, the questions I'm going to have is about his intent and his conduct and his actions during this period of time.

So he leaves the hospital January 2nd at 11 a.m. If we scroll down we know at 1:20 p.m. he's in Guysborough. He makes a call to his friend Kenneth Greencorn. Mr. Greencorn describes them as hanging out. He advised Mr. Greencorn that he spent the night at St. Martha's. He brings up the topic, as you referenced earlier, about putting the truck in the ditch at New Year's, the argument with Shanna Desmond. They discussed topics of divorce and he references that he has a counselling appointment tomorrow. So on January 2nd he's thinking about and mentions he has an appointment tomorrow.

His demeanour by Mr. Greencorn is feeling pretty good. These are his direct comments, if we can scroll down, "Feeling pretty good, joking, looked all right, seemed normal to me." So that's his sort of demeanour that afternoon as he gets out of the hospital.

That afternoon after the Greencorn interaction, 2:42 p.m., he's then in Port Hawkesbury. That's where he attends a Canadian Tire store and he purchases a buck knife and socket set. We can show you, I guess, photos of those exhibits but are you familiar that the buck knife was actually found at the scene of the homicide? Are you familiar with that?

A. Yes.

Q. And the sheath that the buck knife belonged to was attached to Lionel Desmond's belt I believe at his side. Are you familiar with that?

A. Yes. Yes.

Q. Okay. If we could scroll back. So he purchases what is eventually an item that he brings to the scene of the homicide the next day but he also purchases a socket set. There's no suggestion in the report that the socket set ... RCMP are reporting that that was attached to any homicide in any way. We all know, I guess, what a socket set is used for.

If we look at the same date, January 2nd, he's back in Guysborough, he has a second call to Kenny Greencorn, Kenneth Greencorn, and it's about the snowblower. Can you scroll down?

He's asking Mr. Greencorn to pick up the snowblower, to sort of service the snowblower. It's at this point he advises

Kenneth Greencorn he just got out of the shower. He says Shanna and Aaliyah were gone. And his direct quote that was taken out of Greencorn's statement is: "They took off on him and left him so he said he was getting out of there."

His observed demeanour was described as kind of upset and they both returned to the Greencorn residence where he spends the night. He's described that he stayed there before in times of sort of not getting along with Shanna.

If we scroll down. That same night he makes a call to his therapist, Catherine Chambers, and leaves her a message asking about the date of his rescheduled appointment. I promise there's questions of this but I think there's value in the review.

So January 3rd is the next thing we know, 1 p.m., this is the date of the homicide. He's now in Antigonish. When he's in Antigonish he goes to the St. Martha's Hospital following up with what Dr. Rahman recommended to him is that he reschedule his appointment with Dr. Slayter and he does that. So he's thinking towards the future and he gets a rescheduled appointment with Dr. Slayter, I believe it's for, if we scroll down, January 18th. So a date that's going to post-date the homicide.

When he's at that clinic which he decides to attend in person and drive to Antigonish to do so, he's there for about five minutes. He's described again by the clerk that works there as very calm, very polite, thankful to get an appointment and nothing was out of the ordinary with his presentation.

If we scroll down. Scroll down further. And right around this same time that he's in Antigonish and reschedules the appointment into the future with Dr. Slayter he then has a call to Catherine Chambers. And you had cited the dynamic and the interaction in your report between Chambers and Lionel Desmond, so are you familiar with what transpired over that phone call?

A. Yes.

Q. So generally ... that phone call is recorded as being 26 minutes. He then starts to report the concerns that were the backseat driving and putting the car in the ditch at New Year's. He starts to kind of speak about that further and talk about the argument with Catherine Chambers and he starts to go through it. If you could scroll down. And it's at that point he indicates to Chambers that Shanna had asked him for a divorce. He talked about being stressed, being anxious. He reported the increase in his PTSD symptoms. He told Chambers about staying at his aunt's place and he talks about he needs to find an apartment as

his wife and daughter are staying in the home. And that's when the verbal contract, I guess, enters into play where she says if he continues to feel overwhelmed or unable to cope he would make that contract and go to the hospital.

(12:20)

So if you scroll down and keep going down. But he ... during this call reschedules - another forward thinking - an appointment for January 5th, 2017 with Catherine Chambers. So there's some contemplation that he's asking for when the next appointment is, she says it's going to be on the 5th.

He again talks about the expense of moving back and forth. If you could scroll down. Keep going down. Keep going down. She describes him as ... "He did not sound particularly ..." this is Chambers. "He did not sound particularly agitated, she said, that's something I was listening for. He was calm. He said that he didn't have any plans to hurt himself or anyone else." So again he's telling the therapist or a health professional he has no plans to hurt himself or anyone else.

He shifted to speaking very specifically about his plans for the future. He noticed that he was going to have a look for a safe and affordable housing. He talked about

wanting to make sure that he had access to his pensions. He talked a lot about banking and housing.

And, in particular she says, "So he was orientated to the future." She says, "He was speaking in very practical terms of what his next steps would be."

If you could scroll down. Keep going down. And then they have the conversation about she reports, "And I said ... or if you have any thoughts of hurting yourself or someone else that would be a reason to go back" in relation to the hospital, and he assures her yes.

So would you agree that Lionel Desmond's presentation to Catherine Chambers during that call is very much I don't plan on hurting myself or others?

A. That's correct. And at least in the context of that conversation oriented to the future in terms of some of the plans that he has going forward.

Q. Okay. If we scroll down. She described, and you noted this in your report that:

His demeanour during this call was similar to the demeanour she observed in the past which was flat. His demeanour was meek and

child-like. He was very polite, soft spoken. His speech was often confusing, fragmented and disorganized. It appeared to be difficult for Mr. Desmond to think and express himself clearly or in a linear fashion.

I'm going to ask you a little bit about that as well when we get to the question portion, I guess.

The next significant entry is after that call with Chambers he calls Family Services Eastern Nova Scotia. He has a couples counselling appointment set for January 16th, so again in the future, and they report during the call he says that he wants to change it from couples counselling to personal counselling. And it's operating on the principle that he's going to attend the appointment but it's for himself, not for himself and his wife.

Then a few hours after that he's at the gun store. As you know he buys the firearm. He's described very polite, outspoken, well mannered, casual and relaxed customer. If we'll move down. And that's when he purchased the firearm but what is notable, Doctor, is he chooses between bullets. And in fact has a brief conversation and picks the bullets that are not going to be corrosive, the more expensive bullets, presumably not

corrosive for the gun, that would sort of look at the long-term care of the firearm.

And then as we know, the tragedy happens at 6 p.m. He's dressed in full green camouflage, in possession of the knife, and we know what takes place/happens and there's no need to really review that.

So, Doctor, I have a series of questions. First, I guess, what do you make of Lionel Desmond's forward thinking which was very much he buys the knife but at the same time ... he buys a knife that is at the homicide scene but at the same time he buys a socket set. He follows up with Dr. Rahman's recommendation to make a future appointment with Slayter. He follows up with Catherine Chambers about a future appointment and he talks about this to Kenny Greencorn about an appointment in the future. He, as well, talks about other future orientated behaviour which is the non-corrosive bullets. Family Services Eastern Nova Scotia, appointment into the future but it's now himself.

How do you reconcile that future-based conduct and thought with buying the firearm within the same timeframe and doing what he did?

A. In some ways to me that's really the crux of the issue and it's an issue for which I don't have a ready explanation.

You're correct, so on the one hand he has several contacts with individuals over time that would suggest that he's oriented to the future and making plans for doing things. There are also some indications that potentially he was thinking of ultimately what happened in advance by going to the Canadian Tire store and getting the buck knife and certainly purchasing the firearm. Although even in regard to that, you know, for somebody that was constantly concerned about his finances, to buy the more expensive rounds of ammunition would seem/strike me as a bit odd so ...

So the two scenarios in my mind are that at some point he knew in advance what he was planning to do but maintained a facade, if I can call it that, of normalcy up until the very end.

The other is he was an individual who was planning for the future but there was some sort of intervening event about which I don't have information that occurs in s relatively short period of time that leads him ultimately to the actions that he took on that date. And it's very difficult without Mr. Desmond being here, of course, and knowing what the internal thought process in his mind was at the time of those events that come down on one side or the other of that particular equation,

although other than to say that at the every end I think that the information would suggest that those actions were deliberate on his part, at least with respect to the death of Shanna Desmond and then his mother and daughter after that.

Q. When you say about the facade of normalcy what do you mean?

A. Well, the closest reference point I have is for ... sometimes individuals with suicide once they've made up their mind to commit suicide that there's almost an internal sense of relief. So the distress that they were feeling dissipates in the sense that they have now got a definitive plan in mind for what's going to happen next so they don't have to wonder or worry about how am I going to manage or not manage, it's I'm going to deal with this in a final sort of fashion.

So in that way individuals with suicidal ideation can sometimes present as being relatively well when they present to others at that period of time.

Q. When ... what do you make of sort of reconciling this sort of polite, calm demeanour when he's rescheduling the appointment; the very happy, calm customer who is, by all accounts on the video, interacting normal with someone within hours of all of that is described as very disorganized thought

as Catherine Chambers put it, and she was very descriptive that he was very disorganized in his thought process, that was alarming to her. What are you sort of making of that, in that we have people interacting with him by all accounts he seems very normal and then there are aspects of somebody that's very disorganized in their thought process? What are you making of that?

A. To me it would suggest that when he had that conversation with Ms. Chambers that he was experiencing some sort of inner turmoil, so to speak, and that was distracting him from being really focused in the conversation with her, such that he comes across as quite disorganized in his speech.

The other possibility of course would be some sort of substance use, but I would presume that that would be apparent from the toxicology reports, although I don't know that I've seen those.

(12:30)

Q. And we've heard some discussion about when a woman discloses that it's over, it's final, she's leaving, that that is sort of a sign of the highest point of risk that she finds herself in. Do you agree with that sort of analysis?

A. Well, certainly what we know about homicide/suicide is

that the vast majority of them occur in the context of an intimate relationship and that the sentinel event is often that sort of discussion with the partner, that it's the end of the relationship, they're leaving or they're about to leave or they're going to get a divorce, that sort of thing. So, yes, I would agree with that assessment.

Q. You were under the impression that at some point Lionel Desmond formulated the intent to murder Shanna ... or I apologize using the word, commit an act of killing Shanna Desmond, but homicide is the term you used. Are you able to comment as to when that intent formulated or when it started to formulate?

A. It's a very difficult question to answer. Of course, we know that he had had chronic ideas concerning his wife for some period of time. It seems that, as we've discussed, was accentuated following his return to Nova Scotia. The event of New Year's Eve stands out as an event for which further sort of underscored those difficulties because that was an event which, from the documentation reviewed, he became quite perseverative about and sort of arguing with her about what that meant. So, as we've discussed, it's difficult to know that when a person says, you know, Do I feel suicidal? No. Well, I might mean it

in the moment but, six hours later, I'm suicidal again. But those factors, including the accident and then the discussion that he reportedly had with Shanna Desmond about the divorce seemed to be, they might have been triggers in the sense that they then led him to become more preoccupied with how to resolve that issue in a more definitive kind of way which led to the tragedy.

Q. Much like the question I had asked you about the year prior, November 27th, about Lionel Desmond's accuracy in reporting whether he had intent of harm or a plan to act upon a suicide ideation. We have seen that similar dynamic where he gave assurances multiple times to, and through the course of a discussion, to Catherine Chambers. So I guess are you able to comment again, how reliable is Lionel Desmond's word when it comes to, I have no intent to act upon this and I have no plan. How reliable is his self-reporting to clinicians?

A. Well, of course, we know in the end it wasn't reliable in the sense that the event occurred, notwithstanding the conversation that he had with his therapist on that date. Again, that's just one of the imponderables that I have. I can't really definitively say that when he spoke to Ms. Chambers that he really meant what he said or whether he was simply

saying that because he may have had concerns that if he responded in a different way that his ability to make the choice that he ultimately did would have been taken away from him.

Q. And I'm mindful that no healthcare provider has a crystal ball and I'm mindful of the fact that you talk about the ultimate statistics as it relates to suicide, but then when you come to suicide/homicide, how difficult that is, because it is such a small, small rate. But my question, I guess, is along the course of the information that's documented, is there room there to sort of begin a risk assessment for violence and intimate partner violence with Lionel Desmond along that chain of healthcare providers given the information he provided to them?

Q. I think there were opportunities along the whole continuity of Mr. Desmond's care over the course of years. So from very early on, the issues with his wife stood out as an ongoing source of difficulties for him, both in terms of the treatment of his illness and in terms of his maintaining any kind of emotional stability. So having addressed those issues early on and then in a continuous kind of fashion would have been assistance in, as we've discussed, not necessarily predicting that ultimate outcome but sort of at least doing what

one could in a preventative frame to sort of prevent it from occurring.

Q. We have asked you a lot of questions about Shanna Desmond and Lionel Desmond's intent and views as it relates to her. I'm trying to have some sort of understanding of what it was he ultimately did to her. And his mother, Brenda Desmond, and Aaliyah Desmond have counsel here today and we didn't sort of deliberately ignore that fact but left it sort of to the end, I guess, in the sense of what do you make of the fact that he showed a lot of views directed towards Shanna Desmond but little, if anything at all, to his mother and daughter. In fact, all indications were he loved his daughter. What do you make of the fact that he kills his daughter and his mother during this course of events as well?

A. Again, it's difficult to be specific. We know from the information available that Mr. Desmond intentionally killed Shanna because we have the information from, I think it was George Desmond, if I have the name correct, that he had received a call from Mr. Desmond's mother just at the time of event, said, The boy has gone and done it, he shot her. So we know that that was, in all likelihood, the first event that occurred. So it may be that he was planning a suicide/homicide and then,

with the presence of his mother there and his daughter, that somehow some other event intervened, whether he just felt overwhelmed in the situation and felt that there was another final solution waiting there for him, you know. Sometimes people theorize that the killing of a family member is, in a misguided kind of way, an attempt to sort of save that person from the future harm that they would be better off deal theory than living in sort of a world in which they don't have any parents available for them, those sorts of theories so ... But, ultimately, it's hard to know what his motive was or if there was an instigating event that occurred between the death of Mr. Desmond's wife and the rest of his family.

Q. And ultimately in your report, you went through a number of different categories in the literature as it describes homicide/suicide scenarios and did you put this particular sequence of events, this tragedy, in a category of homicide/suicide?

A. His would fit what the literature commonly refers to as a familicide suicide, which is even rarer than homicide/suicide. As I've got noted there:

> It involves a depressed senior man of the household, often associated with

precipitating stressors and marital problems, finances or work-related problems. He may view his action as an altruistic delivery of his family from continued hardships, may suspect marital infidelity and be misusing substances, (which there's no evidence in this particular scenario). And there's usually evidence of depression or depressive cognizance (judgement?).

So he meets that particular sort of listing of the typology of homicide/suicide cases.

Q. And when you say he meets that typology, are you able to say how well he may fit into that category?

A. Well, one of the issues with the typology is it's really a focus on the phenomenology of the type of the event that occurred. So, in that way, he meets those criteria of the event as it occurred and he meets the criteria in what's hypothesized to be the potential sort of mindset of the individual engaging in that behaviour.

(12:40)

Q. In the evidence of the RCMP, they talked and made note of the fact that where the vehicle was found. You're familiar

that it was found behind the residence in this sort of log road. It wasn't sort of just pulled up to the house, it was down a road, he would have had to track behind the house into the house, and the fact that he's wearing a military camouflage totally all over, he has a knife strapped to him. So what do you make of that sort of behaviour in that it's not just him pulling up to the house with a firearm dressed in the same clothes as he was in the gun store. He actually changes, puts on a knife that he bought earlier with the socket set and then he comes in from behind the logging road. Do you make anything of that?

A. Well, the forensic psychiatrist in me would suggest that that was intentional on his part perhaps to avoid being seen or to be able to sort of approach the house in a way that would be otherwise undetected. Part of it is the wearing of the camouflage could be part of that. Part of that for me is sort of wearing more of a therapeutic kind of lens would be that perhaps in a distorted kind of way this was a veteran so it was perhaps his way of leaving with a sense of honour, distorted as that might sound.

Q. In terms of looking at his intent, was there anything suggestive of sort of planning on his part as opposed to sort of

just a spontaneity of being in a circumstance and then this happens.

A. Well, as we discussed earlier, there are several elements that despite his possible comments about future planning would be suggestive of planning. So the purchase of the buck knife and the purchase of the weapon, in particular, would be suggestive of a planning, particularly for an individual that had chronic suicidal and homicidal ideation. So that would be an element of planning from my perspective, as well as the way that he arrives ultimately at the scene of the tragedy and the clothing that he's wearing at the time.

Q. And does that suggest to you sort of taking it from, I wanted to say disease of the mind, sort of does it take from the aspect of mental disorder not being able to appreciate his acts to being able to very much understand what it was he had put in place and did?

A. In my opinion, yes. I think that ... I mean ultimately the evidence would suggest that he was aware of what he was doing, that that was ... the ongoing question that I always have in this particular matter is that although I'm confident that his intent was to kill his wife and then, in all likelihood, then immediately kill himself in sort of the typical

sort of homicide/suicide picture. The presence of other family members there becomes ultimately a very tragic feature of the whole presentation and to what degree that was intentional or, if it was intentional, sort of only intentional on impulse at the last moment is hard to reconcile.

Q. Is there any correlation between homicide/suicides and firearms?

A. Most of the literature on that topic comes from the US but the literature that there is on it would suggest that overwhelmingly the offences that occur with a firearm is that the main, something on the order of 90 percent or more, I think, are committed with firearms.

Q. And I don't ... I'm mindful, you know, I don't want to revisit the horrific facts of exactly how the deaths took place but I do just want to know if you have any sort of comments with respect to the nature in which he had killed his wife, his mother, and daughter. And, in particular, his daughter, it was a very directed manner. Do you have any comments on that, any insight?

A. Well, of course, I'm not a weapons expert, of course, but it would suggest that the death of his daughter was intentional and not accidental through some sort of misfiring of

the weapon or something like that, I would suggest.

Q. Okay, I'll leave it there. I don't really see any value in going further. Your conclusions ultimately in your report at page 23, I'm wondering if I could get you to sort of articulate. We went through and we broke down a number of pieces as we got here but if you could tell the Court, I guess, generally what your conclusion is with respect to you being asked to do this psychological autopsy to examine the tragedy.

A. For me, I think my role in all this was to try to understand more clearly what the potential interplay was between sort of Mr. Desmond as he was as a person, both pre- and post-deployment, how that interrelated with the development of his PTSD and how the PTSD both interacted with and was influenced by his ongoing issues within the context of the difficulties in his relationship, which developed over time. How those different variables were dealt with in a clinical fashion and how those factors came together really as we've discussed in sort of either a sentinel event or a number of steps that led to a course of action on Mr. Desmond's part which, in my opinion, was intentional, at least in its initial intent of completing a homicide/suicide scenario, but which tragically involved two other family members who were present at the time. So that was

my overall process in engaging in the review.

Q. In terms of your expertise at the beginning, we had reviewed that you're very much involved in sort of quality control, risk prevention, best practices. So I'm going to put you on the spot here a little bit in that part of the ultimate task for His Honour is to come up with recommendations from the various areas and you have a unique one in that you bring a viewpoint of a psychiatrist in terms of practice and mental health setting in evaluating risk and preventative tools. So I'm wondering if you could comment on any specific recommendations or thoughts you have with respect to ways to improve things or change the way things are done.

A. As I think about it over the course of our discussion and over my review of materials, some of the recommendations I would have in my mind would be ways to reduce the barriers to the transfer of information so that there were mechanisms in place that would allow for the speedy transfer of information from clinician to clinician so that that information would be more readily available to the individual. To do that requires some consideration about other issues which are outside of the scope of my practice. So those would include sort of issues about patient rights for information, control and all those

sorts of issues. But that would be one recommendation going forward.

(12:50)

We've talked a lot about sort of whole process of transferring from clinician to clinician. So having processes in place that allow for that warm handover so that there's minimal amount of downtime between when a person transfers from one clinician to another to allow for ongoing continuity of care, to the degree that it's possible, in fact, although between different organizations, it would be a difficult task, I would think, to have an individual who has maintained a good relationship with a client to be able to maintain that relationship over time would be another one.

We've had some discussion about suicide risk instruments and related instruments related to risk of violence use. A potential idea would be to see whether there are ways to better refine those instruments, particularly for different subpopulations of patients so that not so much that they are going to more easily predict whether somebody will do something or not but rather so that they can be more fully integrated into some sort of ongoing treatment plan that help to sort of recognize and manage those risks over time.

So those are some of my recommendations, as I think about it.

Q. Do you have any recommendations or thoughts as it relates to sort of global education of healthcare providers in the area of domestic violence and risk factors for domestic violence?

A. That's an area that we, certainly in my residency program, that's an area that we devote a fair amount of time to. So that would certainly be a recommendation, not just with respect to psychiatric staff but I think any clinicians within my broader role as sort of the clinical director for Mental Health and Addictions in the Central Zone, as we, on board is the new term is for individuals, the staff into our services that we're increasingly looking at what are some of the required skillsets that individuals should have to be a clinician. So recognition of and some ability to manage issues related to domestic abuse would be useful in that regard and, to that extent, that would require upscaling and education of clinicians in that area.

Q. In terms of, you spent a great deal of time talking about rehabilitation but through the perspective of community and social supports. Do you have any comments or sort of ideas

of recommendations as it relates to that aspect of rehabilitation?

A. Again, if we look at different subpopulations of patients, and in particular we look at patients who have more complicated histories, particularly if it intersects with other areas like social areas or, in this case, marital areas and having the availability of, for example, some sort of case management function to help sort of that individual navigate those systems would be useful.

Q. What about in terms of anything unique to veterans and their rehabilitation and health ... mental health?

A. I think that would also be very useful there. I mean one of the issues, of course, with veterans is that veterans, as I understand it, have the option to opt into some of the services that we provide; for example, the OSI clinic that we have in Halifax or not to opt into that kind of process. But for veterans, particularly veterans who have complicated issues, as was the case with Mr. Desmond, to have those kind of case management functions, regardless of whether they're within the OSI service or within the general service would be useful to have.

Q. Any comments on recommendations or opinions on

recommendations as it relates to mental health and rehabilitation unique to recognition of race?

A. The issue of race is one that's become thankfully part of the common discourse both in broader society as well as the mental health for a number of years now so ... And we increasingly think about trying to maintain clinicians who have cultural competency, as we would say. So sort of an appreciation of and some understanding of the unique issues that individuals from marginalized communities and racialized communities and our First Nations populations have in terms of their mental health, particularly as to how their mental health issues may present differently.

One of the issues that we face on a regular basis is that within Mental Health we have limited, we've had, historically, limited success in engaging individuals from different ethnic backgrounds in racialized communities into the mental health system and we need to do a better job of understanding why that is and look at mechanisms that we can use to try to develop systems that allow individuals from racialized communities or other communities that are not part of the traditional experience that people have with our mental health services to feel comfortable engaging in mental health programs.

Q. And rural or access to resources and the interface of resources in rural communities, which was sort of a theme in this Inquiry. Do you have any comments, recommendations, or suggestions as it relates to that area?

A. Part of my work as a member of some of the senior leadership team for Mental Health and Addictions for the province is that we're trying to deal with some of those regional disparities that we have between urban and rural centers. So a part of that work, as I think I discussed fairly early on in our conversation, was looking at making sure that wherever you are in the province that you can have some expectation of similar quality of services available to you. How we do that is a challenge in the sense that rural communities, by their nature, are more isolated from those centers where we may have the resources available to us. So we're in the process of trying to design models within our care programs that try to account for that by leveraging technology, by leveraging, for example, group processes so that we can have, given a limited number of resources, have more people involved in sort of a group process than might be the case if they were expecting to get it on a one-to-one process, for example. So those are some of the processes that we're trying to develop.

Q. And, finally, sort of any recommendations or comments, there are a lot of healthcare providers who are very highly qualified and did excellent work. I know that's an opinion that I am perhaps not qualified to make but, in a fair comment, is there any ... do you have any recommendations or comments with respect to how the pressures on them or the way that they're ... I'm thinking of, say, the psychiatrist that sees the person in a moment of crisis in the ER, much like Lionel Desmond at the last minute, at the very end. Catherine Chambers, who received that call. Do you have any sort of recommendations or insight to offer that could perhaps take some pressure off them or serve to help orientate them as well when someone such as Lionel Desmond appears before them at the last moment?

A. The thing that comes to mind really is that if a client had an active treatment plan that was modifiable such that it could be sort of changed over time as the individual's situation changed, and that that as a synopsis was available to a clinician who sees an individual who they otherwise don't know would be helpful for them in terms of sort of giving them more confidence in the decisions that they ultimately have to make in terms of things that present generally, for example, in the

Emergency Department.

Q. Well, that would be, you'll be happy to know those are all my questions, Doctor. Thank you for you work and certainly the insight that you've offered here so far today, but that would conclude our evidence, Your Honour.

THE COURT: Thank you, Mr. Russell. Dr. Theriault, Counsel, I think we will break for lunch and come back at 2 o'clock. But I'm just going to canvass the room before we go. Mr. Anderson or Ms. Lund, you'll have questions?

MR. ANDERSON: We won't have any questions.

THE COURT: You'll have no questions. All right. Ms. Ward?

MS. WARD: Yes, we have some questions.

THE COURT: You'll have some questions. All right, thank you. Mr. Macdonald?

MR. MACDONALD: I will, Your Honour, yes.

THE COURT: You'll have some questions as well. Mr. Rogers?

MR. ROGERS: Yes, we have some questions. Thank you.

THE COURT: Thank you. All right, Ms. Miller?

MS. MILLER: We have some questions, Your Honour.

THE COURT: Mr. Rodgers?

MR. RODGERS: Yes, Your Honour.

THE COURT: Thank you. Mr. Hayne?

MR. HAYNE: I don't anticipate many questions, if any.

THE COURT: All right, thank you. So this is going to be my question to Counsel. We come back at 2 o'clock. I would like to finish by 4:30. If we're not going to finish by 4:30, either we will have a break for refreshments and come back so that we can finish with Dr. Theriault today. We have Dr. Jaffe scheduled for tomorrow but we have flexibility there. We can move Dr. Jaffe a little later in the day. And I don't know what your plans are for but maybe we'll have a discussion when we adjourn but I'll just let counsel think about that as well. So we'll come back at two o'clock. Just stay for a minute and we'll have a conversation, Dr. Theriault. Thank you, Counsel.

COURT RECESSED (13:01 hrs.)

COURT RESUMED (14:02 hrs.)

THE COURT: Thank you. Mr. Anderson, I understand you have no questions?

MR. ANDERSON: Correct, Your Honour.

THE COURT: Thank you. Ms. Ward or Ms. Grant?

CROSS-EXAMINATION BY MS. WARD

(14:03)

MS. WARD: Thank you, Your Honour.

THE COURT: Thank you.

MS. WARD: Good afternoon, Dr. Theriault. My name is Lori Ward and I'm representing the Attorney General of Canada, and that includes any federal entity including Armed Forces, RCMP, and Veterans Affairs.

A. Okay, thank you.

Q. So in preparation for your report, we understand that you reviewed voluminous materials as well as interviewing some people, and you had expressed a desire for practitioners, such as an emergency room doctor, to have access to more information on a patient. And I think that you expressed that it would be good to have collated material or maybe summarized material. I wonder if you could comment on the feasibility of that sort of thing in our current system?

A. Well, that's a good question because, of course, one of the issues is that, to the degree that that information is available, it's not normally in collated form, and, in the context of an emergency room setting, you have limited time to sort of review and digest, so to speak, the information that is

available to you because you're under a certain amount of pressure, usually because there are other demands on your time if you're an emergency room physician, whether that's a psychiatrist or general practitioner.

So having that information in an easily-digestible form would be ideal, but the practical problem with any of the systems that I deal with is that information is not, either from software or logistical issues, it's not easily available in a collated form, so it tends to be, if you'd had the time, you would have to go through it page by page to sort of get a broad overview of the subject that you're interviewing.

Q. And I think we've heard from some witnesses, or it's been a common theme, that more information would always help, but sometimes too much information ... a busy practitioner, like you said, might have three or four people waiting in an emergency room and it's just not feasible. Sometimes more information is too overwhelming. Is that fair to say?

A. I think it's fair to say because, I mean, and it's also context-dependent. So, for example, when you're dealing with somebody in an emergency room setting, your goals are a little bit different than when you're dealing with somebody ... if I'm dealing with them in a regular practice. So, in regular

practice, I have really the luxury to sort of take my time to digest all that information and sort of use that in a reasoned way to sort of create a treatment plan for the individual.

In the emergency room setting, you're usually dealing with, to use a shorthand, sort of a "go/no go" situation. Your primary concern within psychiatry is, you know, is this person safe enough and well enough to be out of hospital or is the situation such that the acuity is such that I need to bring them in? So you're faced with a more truncated decision in that sense. So, in some ways, having too much information might distract you from that goal.

Q. And, say, even if you had a patient who you'd been following for some time, if that patient was going to move to a different place and take up with a new practitioner, even a person in that situation who was, you know, looking at a long-term patient/client relationship probably would not have the time to review all of your notes. They would look to summaries or treatment things; summaries like that. Is that fair to say?

A. Prior to their first meeting with the client, you mean, sorry?

Q. Yes.

A. Yes. Normally, what I will do is if I'm seeing a

client for the first time, I will ... In Central Zone where I work, we have OneContent, right? So I will tend to look for summary documents - so summaries of assessments, summaries of sort of discharge summaries, that sort of stuff - rather than sort of detailed note-by-note descriptions of the progress of the person over time because it's just ... Presumably, if you've documented accurately, then that information is there in just a more condensed form.

THE COURT: Sorry, I'm going to ask a question. So in the OneContent system, is there an actual category of summary for documents? Is there some place you can go for a heading in summaries and pick out the summaries or do you kind of, sort of, look through?

A. Well, in our OneContent system, it's listed by encounters, so the encounters meaning the date that you saw the particular person. But you can open up those encounters and you can relatively quickly scroll down through those and look for summary documents. And if you go to an encounter that encompasses, say, an inpatient admission to hospital, then it will have a category that says "Discharge Summary" which is always a typed discharge summary.

THE COURT: All right, thank you. Sorry. Ms. Ward?

MS. WARD: So in psychiatric or psychological assessments by practitioners, you're often relying largely on self-reporting by the patient. Is that correct?

A. That's correct. And, certainly, there's a distinction to be drawn between what I do in forensic psychiatry and what I do in civil practice. So, in civil psychiatry, for example, the norm is that you take the patient at face value, so to speak, you take the person as he or she presents, whereas, in forensic psychiatry, it's simply because of the nature of the work that I do that there's a little more to it than that in that that's only one aspect of what I might look at.

(14:10)

Q. Okay, because I think Mr. Russell touched on this as well. He was kind of talking about maybe the different aspects of Mr. Desmond, and I think that you had stated that sometimes patients are not always totally honest in what they're thinking and feeling or, I guess, what they've done. Is that fair enough?

A. That's true, yes.

Q. And we know from this file that Mr. Desmond was no different. I think you've seen some of the texts that he wrote to his sister-in-law. Some of them seemed quite horrific,

containing, you know, violent threats or the like. And, at the same time, we've heard from his practitioners and clinical clinicians that he presented as very polite, soft-spoken, and those two things are not necessarily mutually exclusive. Is that also fair?

A. Yeah. I mean they're not incompatible in the sense that in any sort of psychotherapy, it's sometimes difficult to draw the distinction between somebody that's having fantasies of a particular event versus whether they actually have the intent to engage in that event.

Q. So I want to talk about suicidal ideation for a minute. You said at page 19 of your report, you talked about Mr. Desmond's suicidal ideation as reported to others, which raises the question ... I guess a lot of our discussion has been how do you objectively assess a suicide risk when suicidal ideation is as he reports to others and you don't really have any objective evidence? You're largely relying on what the person says. Isn't that correct?

A. You're largely relying on what the person says. The only other objective evidence that you would have, and I don't think it was present in this case, is whether the individual in this case, Mr. Desmond, had any prior suicide attempts. So

those would be more objective data about sort of the continuation of suicidal ideation, for example.

Q. Right. And you didn't see any evidence of an actual suicide attempt on his part in the file, did you?

A. Not that I saw, no.

Q. You reviewed the evidence of Dr. Isabelle Gagnon who was his psychologist at Ste. Anne's, did you?

A. Yes.

Q. And I want to bring up the transcript of her evidence on the 3rd of March, at page 91. So she was talking about those borderline personality traits and I think we can all agree that there's no basis to actually diagnose Mr. Desmond with borderline personality disorder. As I understand it, you would need to know more about his childhood to do that. Is that fair?

A. Yes, that's fair, because, of course, when we consider personality disorders, we look for the genesis of some of the features of a personality disorder before the age of 18 because you can't make a diagnosis of a personality disorder until the person is 18, and there wasn't any evidence that I saw that suggested that Mr. Desmond had borderline personality disorder before that period of time as exhibited by any of the issues related to mood instability which came later on.

Q. Okay. So one of the things that ... this was in a discussion with Dr. Gagnon about those traits and potential personality disorder, and she was asked at line 20 at the bottom of the page, "And did you see a fear of abandonment with Lionel Desmond?" And she answered, "Certainly a fear that his spouse would be ending the relationship."

So did you see any evidence of a fear of abandonment on his part in that aspect or any other?

A. Other than that comment, I'm not sure where I would've noted it particularly, but certainly he did have ... he seemed to be intensely ambivalent about whether she was going to stay in the relationship and whether he wanted to stay in the relationship. And that's certainly part of sometimes what we see in individuals with a borderline pathology of any sort. Because often what happens is that the person engages in one of the core features of borderline ... one of the core borderline traits is the person oscillates between idealization and devaluation of the person, so, in the coarsest sense one day you're a great person and the next day you're not such a great person. So some of that, to some degree, might be present in Mr. Desmond's tendency at times to want to reconcile with his partner and other times want to break up with his partner.

DR. SCOTT THERIAULT, Cross-Examination by Ms. Ward

Q. I want to turn to the incident Mr. Russell brought your attention to that was in November of 2015. And, first, I might ask you, what rises to the level of suicidal ideation? I mean a person could, you know, maybe be thinking about, what would the world be like without me? Or, I'm really depressed today. But what rises to the level of an actual ideation? Do they have to actually contemplate killing themselves?

A. We do tend to consider it along sort of a nexus. So, in its earliest form, it might present as simply, you know, I'm feeling depressed. I wonder whether life is worth living or not; that sort of thing, but you're not actively thinking about harming yourself. Then the next step would be, life might not be worth living and I wonder whether I'd be better off if I weren't here or if others would be better off if I weren't here. And then that can move on to more active thinking about, well, if I were to kill myself, what would I do, which involves a certain amount of at least intellectual planning around it. And then there's more ... the next step on would be sort of more definitive steps about what I would do. And you're always concerned at that point whether the person has the means or if they've thought through how they might engage in such behaviour. So it's sort of a progressive kind of concept.

DR. SCOTT THERIAULT, Cross-Examination by Ms. Ward

EXHIBIT P-000083 - NB RCMP REPORTS - NOVEMBER 27, 2015 - SUICIDE THREAT AND SEIZED FIREARMS

Q. If I can call up Exhibit P-000083, please? So this incident we spoke about this morning; it'll be familiar to you, it's just a different exhibit that I had picked out from the one Mr. Russell brought you to, but, essentially, what had happened was, as we know, Mr. Desmond was texting Mrs. Desmond.

THE COURT: Can we enlarge that, please?

MS. WARD: At the time, we know that Mr. Desmond was in New Brunswick at his house in Oromocto. Mrs. Desmond was in Nova Scotia. We know that he'd been kind of going back and forth between the two places and he sent her these texts. And I'm just going to read from this document which is an RCMP report on this incident. And Shanna Desmond had contacted the RCMP. This is under the entry "2015-11-27". It stated: "Lionel was saying his goodbyes, that he will be resting in peace, to tell his daughter he loved her and that he was going into his garage."

And she understood that to mean where he kept his gun.

THE COURT: Ms. Ward, I'm going to stop you just for a second. We seem to have lost the document.

MS. WARD: Oh I'm sorry.

THE CLERK: No, I'm looking for a page number.

MS. WARD: I'm sorry. It's page 3.

THE CLERK: Thank you.

THE COURT: Sorry. There we go. All right.

MS. WARD: So that's the first paragraph under 11-27-2015.

THE COURT: Beginning, "Writer received a complaint ..."?

MS. WARD: Pardon me?

THE COURT: Is that the paragraph?

MS. WARD: Yes.

THE COURT: Sorry. Thank you.

MS. WARD: Right. So in the middle there, it just recounts what he was saying to Mrs. Desmond in the text messages.

A. Yes, I see that, yeah.

Q. So what I'm wondering, Doctor, is is it possible that a person, in sending texts like that to his spouse - on again/off again, an estranged spouse in Nova Scotia - might not actually have a suicidal ideation, but might be trying to test her somehow or see what her reaction would be?

(14:20)

A. Well, that's certainly a possibility. It's certainly not uncommon in individuals that have suicidal ideation that that involves a great deal of ambivalence as to whether or not

they really want to go through with it or whether there's some sort of other possibility for them. And sometimes individuals will waiver from one side to the other to the degree that they want to sort of redeem the situation and correct it versus sort of commit suicide. And sometimes that ambivalence can be seen in a single message so that the message is a bit unclear as to what the person means by a particular event. So that's not uncommon at all.

Q. So are you saying that that's not uncommon in a person with suicidal ideation or are you saying that that's true, but also that there may not be a suicidal ideation?

A. Well, deriving from our conversation we just had about what suicidal ideation entails, so it generally would mean that the person has perhaps suicidal ideation, but they're quite ambivalent about whether that's, in fact, something that they want to do or not, so that they tend to oscillate back and forth between expressions of wanting to do it and not wanting to do it. And sometimes that can be sort of an attempt to garner support that they might feel that they don't have or, otherwise, what we would call "a cry for help" sort of scenario.

Q. Okay. I want to turn to homicidal ideation for a moment which, I think that you've said, is even more difficult

to predict than suicidal ideation. Is that fair to say?

A. Well, that would depend a little bit on the context. So homicidal ideation ... homicidal behaviour would be easier to predict in an individual that's already engaged in violence, but that's not the case that we have in front of us with Mr. Desmond.

Q. So we've talked a bit about the dreams that Mr. Desmond had - graphic dreams about finding his wife cheating on him and killing her lover or whatever - and that seems to be the biggest piece of evidence, I guess you could call it, for a homicidal ideation. So it's been much discussed. Were there other elements you saw that indicated a homicidal ideation?

A. To the best of my knowledge, much of the content of it was his dreams and his discussion of what those dreams meant or not to some of the care providers that he had. I don't know that I saw any information to suggest that he ever said to anybody else that he had any intent to kill his partner.

Q. So I want to turn back to the transcript of Dr. Gagnon for a moment at page 69, and about line 12, the question is:

> He tells you, 'I dream that I find my wife cheating and I attack her and I attack her lover'. He's told Dr. Ouellette he finds

her cheating. He kills her in the dream. She says, "Mm-hmm."

Q. Did you ever get any sense or try to flush out whether these self-reported dreams were him telling you that these are actually day-to-day thoughts, intrusive thoughts, that he may be having?

A. Mm-hmm. He definitely represented them to me as dreams. I think what you're suggesting, is it possible that people would present something as a dream as being a more palatable way of reporting kind of an intrusive thought? I think that whether it's a dream or an intrusive thought, the most important piece of that would be his reporting that this is something that he struggles with and he finds very difficult, right? That then changes it. That's the distinction between a fantasy, which is pleasurable and, you know, he actively kind of engages in as something that might be a good thing, and something that he finds

distressing, that he wants to get rid of. And so if it was ... and again, this is pure conjecture. If it was his way of saying that this was something happening during the day, the most important piece attached to that was him saying, you know, This is something that I don't want in my life anymore.

So Dr. Gagnon took that to mean that it was not an actual intrusive thought, like a conscious thought but, rather, they were truly dreams. Is that a reasonable assessment?

A. I'm not sure of the distinction. So if they're occurring during sleep, by definition, they're dreams, but the more important question really is, does that dream represent in some way a conscious thought that Mr. Desmond may have had from time to time? We know that dreams, as much as sort of, I think, colleagues of mine that do dream analysis might disagree with me, that we consider dreams to really be a reworking of some of the content of our day. So, to that extent, if Mr. Desmond was having dreams about his wife being unfaithful, or killing his wife, then that would suggest that he was having some thoughts of at least concerning issues about her infidelity. We know

that those were occurring in the daytime, so whether the dreams just represented an exploration of that sort of theme in a dream state or not is hard to say, but intrusive thoughts are something that occurs during wakefulness, so you can't have an intrusive thought while you're dreaming; you can have intrusive dreams, I suppose.

Q. But her indication was that these, whether they were thoughts or dreams, they distressed him and he didn't want these thoughts. Is that some indication that, in his conscious mind, he didn't have a homicidal ideation, or are you able to say?

A. I think because of the same reason that I indicated that, at times, people can have ambivalent wishes and thoughts about their own death in terms of suicide, they may have ambivalent thoughts and wishes about, in this case, the death of another person. So it would be hard to be definitive about it, I think.

Q. Okay. I want to turn to the neuropsychological assessment and potential head trauma. So on page 17 of your report, you mentioned, "Several concussions. Exact details unknown."

Now what we've heard in this Inquiry is that Mr. Desmond had self-reported some incidents of head trauma beginning after

he was released from the military. Well, we know his entire medical file from the military was disclosed to this Inquiry and it doesn't contain any reports of head trauma of any kind. So ...

THE COURT: I'm sorry. We don't have medical reports from his time when he was deployed, do we? Do we have his deployment medical reports?

MS. WARD: Yes.

THE COURT: So from the time that he was deployed. So we have all the medical reports? We have ... include all of his reported engagements when he was in combat in Afghanistan?

MS. WARD: Well, we have all the medical reports from his military career. They don't usually reference an engagement but, for instance, we have the reports from Kandahar with respect to him reporting to sick parade.

THE COURT: All right.

MS. WARD: So I want to talk, Doctor, about his mild cognitive dysfunction for a second. And this was identified at Ste. Anne's and was the impetus for the recommendation for the neuropsychological assessment. Am I correct in understanding that?

A. As I understand it, yes.

DR. SCOTT THERIAULT, Cross-Examination by Ms. Ward

Q. Okay. And you have said that such cognitive dysfunction can be a symptom of PTSD, and I think we've heard that from other practitioners. Is that also correct?

A. It can be a symptom of PTSD and it can be a symptom of major depression which Mr. Desmond was also concurrently diagnosed with, that's correct.

(14:30)

Q. And we've also heard from Mr. Desmond's friend, Orlando Trotter, and I'd like to refer to his transcript of February 18th for a moment, at page 112, beginning at line 8.

And so what we know about Mr. Trotter, and I know that you interviewed Mr. Trotter, and he was with Mr. Desmond during his training in preparation to go to Afghanistan and he ... what he told this Inquiry is that he kind of took Mr. Desmond under his wing a bit, in his communications training in particular, and they became friends as you know. At line eight, part of the question says,

> When you talked about Lionel Desmond's training when ... before you were deployed, you said that his fitness and his morale helped. Did he struggle in other ways with the training or were there other challenges

for him that you recall?
A. I don't want to talk down about him, like my friend, but I found like sometimes it took him a little longer to pick up on things and that's probably his only struggle. Like he was a (super) hyper guy to begin with, like he was just hyper, and that's probably why his fitness was so good was because he was just full of energy. Right.
But some of the training, yeah, took ... it took him a little bit.

So putting all those things together, I guess what I get is we don't really know what his cognitive abilities were before and after Afghanistan and that was part of the point of a neuropsychological assessment. Is that fair to say?

A. Yeah. I mean some of those comments of Cpl. Trotter are consistent with some of the information as well that he provided to Dr. Slayter where he said that school was a struggle. Normally, if school was a struggle it's because you're having social difficulties either in school or at home or ... you may have some sort of specific learning disability or

some other aspect of cognition that's impairing your abilities in the school environment.

Q. Returning to the head trauma for a moment, we talked a bit about the culture in the military. We've talked with other witnesses about, you know, the macho nature of military service, if I could put it that way. We talked a bit about the stigma of identifying yourself as having a mental illness. That's all fair in your estimation. And I'm wondering when Mr. Desmond starts bringing up head trauma in his risk assessment we looked at this morning and also with Dr. Murgatroyd, who is his post-release psychologist at the OSI in New Brunswick, is it possible that a person with this military background would seek to attribute his cognitive difficulties to something organic like a head trauma as opposed to a mental illness?

A. There's probably a number of potential explanations for it. I mean it's ... as I've said, it's not uncommon for people who have mental disorders to have cognitive difficulties. So if an individual has a cognitive difficulty, they may just by dint of having that disorder attribute it to the mental disorder rather than to a preexisting sort of cognitive impairment. It's possible that even minor injuries that would not meet the definition of an injury that would normally cause any degree of

trauma to the head would be characterized by the person in that context of having difficulties as being attributable to that particular incident itself, even though objectively that might not be the case.

Q. Okay. And we do know he was functioning, though. As you said, he had managed to sell his house. He could carry on his day-to-day activities. We know that he had made an appointment for couples counseling on his own and that he later called to tell them it was just going to be personal counseling.

And what we heard from his Veterans Affairs case manager was that she would give him tasks to do. And, you know, we talked about patient autonomy and engagement and that sometimes he struggled and he surprised her. So what I'm wondering is in the context of the neuropsych assessment and the recommendation, first of all, we know they're not easy to get. Is that fair enough? I mean you said that there aren't that many people qualified to do them. Is that correct?

A. Well, psychologists are trained in different areas. One would be neuropsychology. So there's not ... to the best of my knowledge, there's not that many available. Certainly within our Nova Scotia Health, for example, we have a limited number that are available. Many work in private practice which would

be ... then a cost is associated with that as well as sort of a potential wait list of anywhere from six months or more, I would think, to get a neuropsych assessment generally.

THE COURT: That's within the system or privately?

A. Privately.

THE COURT: Privately. Thank you.

MS. WARD: And I think we heard from both his case manager and from Dr. Rogers, who you mentioned yesterday, that ... I think they questioned why if Ste. Anne's had recommended this, that why Ste. Anne's hadn't tried to pursue it while he was there. Because Montreal seems to be a place that would have a greater ability to schedule one than, say, Guysborough or Antigonish. Do you agree with that?

A. Inasmuch as Montreal is a much bigger center, yeah, I would think so. I mean there would be questions about language, of course, whether they had the facility in English as well as French because Mr. Desmond was English speaking not French and he was in Montreal at Ste. Anne's.

Q. So it would be an even ... a longer wait, harder to get in rural Nova Scotia. I think you said it was a limited commodity, I think were your words.

A. It would be ... even in Central Zone where I work,

it's a limited commodity, I would think. Even moreso in rural Nova Scotia, I would expect.

Q. So given all that ... and we know that it was ... his case manager started looking up practitioners who could do that. But given all that and knowing his history and how he had come out of Ste. Anne's and decided to move to Nova Scotia, would it be reasonable to focus first on getting him a treatment provider like Ms. Chambers in order to get him immediately into some kind of treatment?

A. Yeah. I don't think that when he came out of Ste. Anne's, although he hadn't had the neuropsychological assessment done, that that was sort of the driving clinical need that he had. I think it would be more sort of just trying to get him broadly connected with services so that as he settled into his new environment, somebody could take a look at it and say, Well, these are the areas that I should focus on first.

Whether that would be sort of his depression or his PTSD symptoms or some of the social variables that were at play, but inasmuch as we know that he was able to sort of cognitively manage on a day-to-day basis in the sense of being able to complete all the independent activities of daily living, although that might be useful for treatment planning at some

point, it probably wouldn't have been my immediate concern for him.

Q. You talked a bit earlier about patient autonomy and, you know, making your own decisions when you're a patient, so is it fair to say that to a certain extent for successful treatment, you need a level of engagement on the part of the patient?

A. You do. You can't really ... it's very hard to advance in therapy if you're working with a client who, for whatever reason, is reluctant to engage with you, whether that's because they have some sort of personality factors that attributed to it or whether your style of therapy is simply not one that they can resonate with. There are a number of factors. But, basically, the fit between the therapist and the client is of critical importance in terms of overall success in psychotherapy.

Q. And we know that his case manager tried to set up an appointment for him with Dr. Murgatroyd as he was coming out of Ste. Anne's, destined for Nova Scotia, and he turned it down. We also know that his case manager decided to keep his case on, even though it should have been passed to someone in Nova Scotia, in order to give him some continuity to the extent it

was within her control. But I wonder ... he was offered treatment at the OSI. Had a lot of discussion about that. He chose to seek community treatment instead. In your opinion, would the OSI clinic in Nova Scotia have been the best option for him?

(14:40)

A. Given that the OSI clinic in Nova Scotia is focused primarily on the needs of individuals like Mr. Desmond as veterans and they have a particular sort of focus on PTSD, that that would probably, in my view, have been the best place for him to receive services. That's countered to some extent by the fact that in order to drive those services, at least at the time that we're talking about, he would have had to go back and forth some hours' distance to the city to receive that service, which may have been a factor that would mitigate against his wanting to do that sort of thing or ...

Q. And of course, as you said, you can't force a patient to do what you think is best for them. Fair enough?

A. Except in very rare conditions, that's true. Yes. Yeah.

Q. Right. And he did not fulfil any of the criteria for involuntary admission or otherwise, did he?

A. Not that I'm aware of, no.

Q. One last thing I'm wondering. So we know from the investigation after the events that as Mr. Russell took you through, he seemed to do a lot of conscious, deliberate activities that day and the day before. You've seen the video of him buying the gun where it goes on for quite some time. He seems to be calm and polite and even though he's made to wait for some time. He changes his clothes. He parks his car down the road. We also know that he slashed the tires on his wife's truck with the knife.

We also know that, generally on Tuesdays, his daughter would be at an after-school program. And so it's possible that he did not expect his daughter to be there.

Given all that, is it possible that he actually had homicidal ideation towards his wife but did not actually intend to commit suicide that day? Is that a possibility?

A. Yeah. I mean it's always a possibility because just from a statistical point of view, a domestic homicide would be a far more common occurrence than a domestic homicide/suicide. So that's always in the realm of possibility. So it's difficult to know whether, in the end, Mr. Desmond contemplated and meant to kill both his wife, himself, and the other family members or

whether his intent was to inflict a fatal wound upon his wife and then other matters intervened and it became a much more tragic event than it already was.

Q. Thank you, Doctor. Those are my questions.

THE COURT: Thank you.

Doctor, Ms. Ward had asked you a question. It related to comments in relation to Cpl. Desmond struggling in school and the fact that, you know, Cpl. Trotter may have assisted in some of his training and if, in fact, Cpl. Desmond had had some learning difficulties or some cognitive difficulties, they were following him through life. And when he finds himself now in a situation where he's at the residential treatment clinic in Ste. Anne's Hospital and they look and they come to the opinion that he should have a neuropsychological examination because they think they can see some cognitive deficits there potentially, whether those cognitive deficits arose in childhood and followed him through life or whether it was something that arose during the course of his combat, I'm going to suggest to you it really wouldn't matter very much what the genesis of it was. The fact of the matter is if it's been identified, it can affect whatever treatment protocols or regime is going to be put in place. It would be important to know that, would it not?

A. The import would really be knowing sort of what the person's cognition is in the here and now, not so much where it comes from, because you want to know what the individual's strengths and cognitive weaknesses are. Because that's the best way to be able to sort of work around them, so to speak, or develop strategies that might assist that individual, so regardless of where that comes from in its background.

THE COURT: It's important to know what's in the here and now, as you say.

A. Yes.

THE COURT: Yeah. All right. Thank you. Mr. Macdonald?

MR. MACDONALD: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. MACDONALD

(14:45)

MR. MACDONALD: Good afternoon, Dr. Theriault.

A. Good afternoon.

Q. So my name is Tom Macdonald and I am the lawyer for the Borden family, so Thelma and Ricky Borden, the parents of Shanna Desmond, the grandparents of Aaliyah, and Sheldon Borden who is Shanna's brother, and Aaliyah's uncle.

DR. SCOTT THERIAULT, Cross-Examination by Mr. Macdonald

I'm really going to start by trying to drill down into a few points in your report and then sort of end with a couple of broader questions, all based on your report. So as I understand your report and your evidence to this point in the Inquiry, on January 3rd, 2017, Lionel Desmond appreciated the nature and quality of his actions and he appreciated their wrongfulness, from your view as a forensic psychiatrist. Correct?

A. That would be my opinion based on all the information that I have. That's correct.

Q. Yes. And in plain English, does that mean he knew what he was doing that day was wrong?

A. I would say so in plain English, yes.

Q. And as I understand your report, Doctor, on that day his actions weren't the result of delusions or disassociation or flashbacks. Is that correct?

A. Well, we certainly have no evidence that it was related to delusions. We've had a discussion about whether he actually had delusions or not. There was no evidence of that.

Q. Right.

A. The information we have about any dissociative phenomena is relatively brief. And we had some discussion earlier today about the waking from the nightmare and assaulting

his wife. But there's no evidence that I have that would suggest that a dissociative event would be as protracted as this particular one was with the degree of sort of, at least by looking at it objectively, the presence of mind that would be required to engage in the behaviour that ultimately he engaged in.

Q. And what the public would commonly call a flashback, is that kind of a subset of a dissociative event?

A. Yes. Flashbacks are sort of a brief dissociative event in which the person is ... in the literature deriving largely from the military, the person feels as though they're back in some sort of ... one of the sentinel traumas that they experienced in the past.

Q. Throughout the Inquiry, and obviously we're dealing with a very difficult subject, and so I had an impression, not saying it's correct, but people don't know really what to say about what happened on January the 3rd. It was an incident. It was a tragedy. It was a terrible event. But in your opinion as a forensic psychiatrist who did a psychological autopsy, with respect to the family members that day, it was murder, wasn't it?

THE COURT: I'm going to just stop you there. Murder

DR. SCOTT THERIAULT, Cross-Examination by Mr. Macdonald

...

MR. MACDONALD: Based on the report, Your Honour.

THE COURT: Well, all right. But ... no. It's just the words you use.

MR. MACDONALD: It is.

THE COURT: Call it a homicide. Right?

MR. MACDONALD: But the ...

THE COURT: But you're asking ... you're asking Dr. Theriault to come to a legal conclusion. Murder is ... murder is a legal conclusion by you. Right? It requires a legal finding. So I don't know that you can ask that question of Dr. Theriault. I think you ... it's ... so you can ask it in a couple of different ways without you labeling it requiring a legal conclusion on the part of Dr. Theriault.

MR. MACDONALD: Sure. So, Your Honour, if I could just respond to you.

THE COURT: Certainly. Yes.

MR. MACDONALD: The ... so I'm not asking for a legal conclusion. But if you ... we could all refer ...

THE COURT: Well, if he calls it ... if you're asking him to call it murder, you are.

(14:50)

MR. MACDONALD: Well, I think he's already calling it that at page 22 of his report, Your Honour. So if we could turn to page 22, Dr. Theriault, please. And just let me know when you're there, Dr. Theriault, please. So this is under the heading, Dr. Theriault, "Issues of Homicide-Suicide". And I'm referring to the first paragraph and the second sentence. I'll read it, "Homicide-Suicide can be defined as 'an act of murder of one or several individuals' ..." And then it goes on. So you're referencing that definition in your report. Do you stand by that definition in your report today?

A. Well, I'm ... yeah. In that particular context, I'm quoting from a text on the topic from an American ...

Q. Yes.

A. ... forensic psychiatrist, so ... and I understand the concerns about a psychiatrist who is not a lawyer sort of using a term that has a legal meaning rather than necessarily a clinical meaning. So in this context, I would tend towards saying that ... in my opinion, that Mr. Desmond's actions on the 3rd of January 2017 were intentional.

Q. Just to take it then one step further, I'll move on. But it's also your opinion that had ... that no defence of not criminally responsible would have been available to Mr. Desmond.

That's in your report at page 17. Right?

A. Not with all the information that I've got available to me. I mean of course I don't have Mr. Desmond to ask those question of myself. But, often, the information that's available is pretty reliable in terms of helping me reach conclusions on these matters. In the absence of anything that would suggest that Mr. Desmond had an actual break in reality, which is what you would see with a delusional system or something like that, that there would be no reason to think that he would meet those criteria under Section 16 of the **Criminal Code**.

Q. Understood. I know Mr. Russell this morning asked you a few questions about what occurred in terms of ... and Aaliyah. I'm going to focus on Shanna. And as I understand it from the autopsy report, she was shot by Mr. Desmond three times. She was shot in the neck, the chest, and in the abdomen. What do you make of him shooting her three times, if anything, from a psychiatric perspective of a forensic psychiatrist doing a psychological autopsy?

A. Well, for an individual that was a rifleman in the services that would have had familiarity with firearms, shooting an individual three times would suggest a great deal of anger, I

guess, would be the easiest way to explain it.

Q. We don't need to turn there unless you need to and you can, of course, by all means. But at page 13 of your report, I'm just going to read a little excerpt. You indicate the case was complicated with respect to other factors such as Mr. Desmond's acquisition of a firearm. Are you familiar with that comment? I mean it's your comment.

A. Yes. Yeah.

Q. Yes. Can you expand and explain that a little more in terms of the overall context of your report?

A. Well, we know that Mr. Desmond had firearms and we know that he was involved in at least one incident where the firearms were taken away after an incident in which his wife had contacted the police. The Inquiry, I think, has had a lot of discussion about how and if and when he got the ability to have firearms back. So that's sort of the broader issue about access to lethal means that we had some discussion about earlier today, as well, both with respect to suicide and with respect to the killing of another person.

Q. So a no firearms acquisition isn't part of your jurisdiction, if I can put it that way ... part of the scope of your report, but you do make a reference to it. I wanted to ask

you this question. I want to set sort of the backdrop, as I understand it. And that's with our Nova Scotia Provincial Firearms Office, the New Brunswick Provincial Firearms Office, which is the office that issued the firearms license to Mr. Desmond.

And we know and I'll start, Doctor, by saying my understanding from evidence from witnesses from both of those offices at this Inquiry to this point in time, there have been changes made since 2017 and this tragic event. So that's out there. Changes have been made in terms of these kinds of matters.

But going forward, with respect, say, to Nova Scotia, maybe it's applicable to New Brunswick, too, if you have a situation where you have an ex-military member who was in combat, who knows how to use weapons, who had PTSD, who had domestic problems sometimes rising to the level of domestic violence where police have intervened, where police have seized firearms from the house ... do you know what a FIP is, Doctor?

A. Sorry?

Q. Have you heard the term "FIP" before?

A. FIP?

Q. FIP is an ...

A. No. Sorry.

Q. ... internal RCMP document. I may have it not completely right, but it means "firearms interest police". So if the police attend, it may not just be exclusive to the RCMP if they attend and they seize weapons, a FIP is generated. So in Mr. Desmond's case, for example, there were two FIPs generated, guns seized from Oromocto, New Brunswick, and then shortly after, guns seized from Guysborough. So we have an individual with that kind of background who then, as a result of that, with the guns being gone, makes ... his firearms license is suspended, for lack of a better word.

He then applies within months to get it back, so to speak, unfrozen. And as part of that process, as I understand it, then and now there is a letter from a doctor that needs to be submitted on his behalf. And it was done for Mr. Desmond then. And, as I say, forms have changed and systems have changed. I don't know how common it would be that we have a person that is a family doctor that writes that letter, but ... another factor, by the way, of course, is a person in that situation, Mr. Desmond ... one of those other factors would be he's presenting with suicidal ideation. That's part of it.

When they apply for the reinstatement and the reinstatement

application, which is submitted along with the letter from the family doctor is considered by the Firearms Office. In the discrete example I've given you where you have all or many of the factors that I've just listed, would it be helpful to have a second level of psychiatric review so that a psychiatrist looks at that application, a second set of medical eyes, to say yay or nay on the reinstatement of the application? Would that be something that would, in your view, be helpful?

A. It's an interesting idea. I hadn't really considered it before. But it's not dissimilar to ... in Nova Scotia, for example, the law in Nova Scotia is discretionary as to whether or not a physician may report another individual for concerns about their driving, for example. And in those cases, the motor vehicle branch of whatever the name of it is, at the moment, can suspend a person's license and, in my experience, it's not been unusual for in order to get the person's license back that they will request a letter from a psychiatrist or psychologist to support that they are now safe from whatever the particular reasons were that the license was suspended in the first place. So extending that general line of thinking to this sort of inquiry would seem to be a reasonable kind of proposition, it seems to me.

Q. Thank you, Dr. Theriault. Your Honour, those are my questions.

THE COURT: All right. Thank you. Mr. Rogers?

CROSS-EXAMINATION BY MR. ROGERS

(14:59)

MR. ROGERS: Dr. Theriault, given that we've known each other since Grade 2 in Digby, it's a little peculiar to be introducing myself. But I am Rory Rogers and together with my colleague, Daniel MacKenzie, we're representing the Nova Scotia Health Authority.

A. Thank you. I'm not used to you with your beard either.

Q. Yes. And when we first met each other, we each had a lot more hair.

I want to ask you a few questions, Dr. Theriault, about some of the content of your report and some of the comments that you've made. I noted from the various materials that you reviewed, that you would have seen records involving mental health services that were provided to Lionel Desmond from what I would generally call three sources. One is mental health services through the Canadian Armed Forces. Is that correct?

(15:00)

A. That's correct.

Q. And then also in the second bucket through what I'd call the private systems. So not through Nova Scotia health system, but he was also receiving some mental health services in a private milieu as well?

A. That's correct, yeah.

Q. And thirdly, and this would be part of your role and responsibilities, he also received some mental health services through the public health system or the public system, correct?

A. Through Nova Scotia Health or through Community Mental and Health and Addictions Program, that's right.

Q. And so what I'd like to do is to get your insight and your comments as to how those three systems work generally and the interplay among them and specifically with respect to Lionel Desmond.

So let's start with the Canadian Armed Forces side. You made some comments earlier in the questions and answers between you and Mr. Russell about Mr. Desmond's involvement with a psychologist, Dr. Rogers, and psychiatrist, Dr. Joshi, in New Brunswick, correct?

A. That's correct.

Q. And so my understanding, and correct me if I'm wrong or if you agree, is that was done really under the rubric of Canadian Armed Forces, correct?

A. That's right, when he was a service member, yes.

Q. Right. Because as a service member I guess you'd be familiar as part of your treatment of people ... I know you spent some time in the Valley, would have seen people at Greenwood, when individuals are with the Canadian Armed Forces most of their medical services are provided directly to them through the Forces, correct?

A. Usually by personnel that are either, themselves, members of the Forces or at least civilian members of the Forces, but they operate within the structure of the processes by which services maintain those records.

Q. Fair. And if I'm recalling the evidence correctly of Dr. Rogers and Dr. Joshi, they were providing as independent contractor psychologist and psychiatrist services to the Forces and its members?

A. That's correct.

Q. And that's typically the role that works in the medical system. Most physicians or, I guess, psychologists within a hospital institution are independent contractor

providing services through that institution or through that hospital with privileges, fair?

A. That's correct, yes.

Q. Okay. And so then when someone such as Lionel Desmond is receiving psychological services while he is a member of the Forces he'll be getting those services directly through the mental health providers who are retained by the Canadian Armed Forces, correct?

A. That's correct, yes.

Q. And I guess the exception might be in an emergency context. So that if somebody did present with a mental health emergency they might present through the health system either in New Brunswick or in Nova Scotia, depending where they're living?

A. Well, sure. If you're living in a community and you have some sort of health crisis, whether it's mental or physical health, and you have to go to the local emergency service you will simply be seen by whoever is operating in that service at that time. So that would be somebody that would be outside of that umbrella of the military provision of service that he was involved in when he was still an active service member.

Q. Okay. So then the second bucket in terms of type of mental health services are the private services. And I know

you've made some reference to some of those private services that are available, let's talk about the various components of that.

In Nova Scotia are there psychiatrists who provide services in a private context?

A. In Nova Scotia there's essentially two models for psychiatric care. One is you work within what we would call the public service, so you work on contract with the Nova Scotia Health Authority in one of our facilities distributed around the province in one of the four zones, so that's probably by and large the majority of psychiatrists.

But you do have a cadre of private psychiatrists who, like other medical professionals, they have a private office and in that context they're an independent operator. They don't report to anybody else. They're not responsible to anybody else. They're not accountable to anyone other than themselves and the College, of course. And the documents that they produce would not normally go anywhere other than their private offices.

Q. Thanks. Same situation for psychologists? There would be, again, some psychologists who are performing private psychology services directly contracting with patients or clients?

A. That's correct. Quite a few in Nova Scotia, I think.

Q. And one of the subsets of those were the neuropsychologists as you just referred to who would do the neuropsych reports?

A. Yeah, we have neuropsychologists both within our public mental health service and in private services. The issue, of course, is that there's not a lot in either one, so if you're contracted to Nova Scotia Health, for example, and you're a neuropsychologist then you've generally got a long list of potential candidates that you could see and the same would be true in private practice I would think.

Q. Okay. So we've talked about psychiatrists having both the public and a private role, same for psychologists. Is it the same for counsellors or therapists, the folks who would do the kind of intensive therapy that you've talked about for folks with PTSD or all those mental health needs?

A. Yeah. No, I think there would be and I don't ... within the Mental Health and Addiction programs, of course, we have therapists of different types, so social workers, occupational therapists, various masters of social work in particular, often therapists.

There are other regulated therapeutic categories in Nova

Scotia and I can't remember all the names, like registered therapists or those sorts of things, but those are primarily in private practice. We don't tend to hire those within our public mental health services but there is an array of therapists both private and practice across both of those sectors.

Q. So again, in the private context you could have people who are social workers, who are another type of therapist, some nurses I know who do some individual private work as well?

A. Yeah, so they would do private work and the same rules would apply in terms of the limits of how that information is shared betwixt parties.

Q. Right. And then presuming that's not funded through the public system, which is why we're calling it private, and where would the typical funding sources be for those private mental health services?

A. Well, for psychiatry it's public in the sense that that would be covered through MSI for private psychiatry, but for private psychologists and other therapists those entities are usually ... the funding either comes from the individual themselves or often it will come from potentially other sources like insurance companies and stuff like that, for example, if a private therapist was seeing somebody for work after a motor

vehicle accident or something along those lines. So different sources but with the exception of psychiatry currently it doesn't come out of the government coffers, so to speak.

Q. So, again, excepting out the psychiatrist who might be funded through the MSI program, the other sources of funding on private side could be insurers, it could be companies where individuals are working, it could be the individuals themselves, is that fair?

A. That's correct.

Q. Also, it can be Veterans Affairs Canada, VAC?

A. It could be as another organization does that.

Q. And the Workers' Compensation Board also provides some of that funding directly?

A. They do.

Q. Again so they'll be accessing those mental health services on the private side?

A. That's correct.

Q. Okay. And then before I next turn to the public system, we've heard a lot of evidence and we've made reference to the OSI system which I guess in some ways is a bit of a hybrid isn't it? Because in the Nova Scotia context the Inquiry has heard evidence that the funding for the clinic and the

services that are provided comes in the Nova Scotia context from Veterans Affairs Canada and the RCMP. Is that consistent with your knowledge and understanding?

A. That's correct, yeah.

Q. But that the services are provided through Nova Scotia Health Authority?

A. Yeah, it was a hybrid system that we put into place a number of years ago. We were one of the last of the OSI clinics that were developed across the country, and so when we developed it here, I think we were the 10th OSI clinic that was developed, we had made a decision that it was an operation that was run through Veterans Affairs Canada, so they continue to provide the funding for it but we provide the staffing for it. So we provide the psychiatry staffing, we provide the psychotherapy staffing, the support staff, all those sorts of things, they're all either contracted to or direct employees of the Nova Scotia Health Authority.

Q. And I think the Inquiry has heard evidence that it is not the Nova Scotia Health Authority gets to determine who comes in the doors, that's the decision that's made by the funders, and then once that decision is made then the services are provided through the clinic and its Nova Scotia Health

Authority-operated facility, fair?

A. Yeah, we manage the facility and we provide the staffing for the facility, but how the clinic actually operates is determined by VAC in consultation with the other OSI clinics so that they try to provide a relatively homogenous model across their different clinics. So that includes training around the therapeutic models that they deliver as well, even though those models are then delivered by staff that are employed by the Nova Scotia Health Authority.

(15:10)

Q. Okay. And then before I move off of the private system and have you talk a little bit about the public system, you made reference earlier to having seen the involvement that a counsellor or therapist by the name of Catherine Chambers had with Lionel Desmond. Are you familiar with her involvement with Lionel Desmond?

A. Towards the very end of his life, yes.

Q. Right. And am I correct in my understanding that that would have been through the private system? Is that ...

A. That would have been a private therapist, that's correct.

Q. Okay. And have you had reason to see other veterans

who are getting those types of therapeutic services through that private system, through that kind of mechanism, is that something you've seen before?

A. Well, I've seen that before and it's not uncommon that we see that sometimes in the public system as well that somebody will come in for public psychiatric or public mental health systems and they're already engaged with a private practitioner so then that becomes an issue for some discussion as well.

Q. Okay. So then the third component of what I wanted to have you reference and talk about the interplay is the Nova Scotia Health system or the public system and really the delivery of mental health and addiction services. So can you describe what the role is of family physicians with respect to that delivery of mental health and addiction services?

A. Well, in any mental health system that I'm aware of we always consider the family practitioner as the person's medical home so to speak. So in most cases within our public mental health system our role as much as possible is to intervene as much as necessary for an individual that may have a mental health problem but at some point return them to their medical home with their family physician. So sometimes that's easy to do and sometimes it's not easy to do.

So, for example, when we're dealing with individuals, say, with a major depressive episode it wouldn't be uncommon for us to see that individual for a single consultation for the family physician, give some recommendations as to how manage the case and then that person would return to the family physician for ongoing care. But for individuals with more severe and persistent illness like schizophrenia, for example, we may engage that person over a much longer period of time.

Q. And I guess you would have seen as part of your review that Lionel Desmond had occasion to see family physicians at various times through the fall of 2016, including a November 2nd visit with Dr. Ranjini?

A. That's right.

Q. Okay. So the second component of the public system that I'd like you to talk about is the emergency department.

THE COURT: Sorry, I'm going to just stop you for a second because I just want to ask one question before we leave the topic of the person's medical home.

How do you deal with an individual who has no family doctor, given that this province there's a great number of individuals who do not have family doctors? So if you have somebody that comes in and you want to ... you know, in a

healthcare setting you deal with them, you're ready to return them to their family home but it doesn't exist. So how do you navigate that?

A. Well, that's a very valid and interesting question because you're right, in the context of where I work in Central Zone probably about 20 percent of our clients that we see for mental health illnesses don't have a family practitioner. So inasmuch as we encourage them to try to get one sometimes that can be quite difficult to do.

So sometimes that means that we have some of our staff managing what would be otherwise routine chronic care, which is like hypertensive medications and stuff like that by a psychiatrist who's not really trained to do that, so it's an ongoing issue for us. So there's no easy ... we've yet to find ... I haven't found an easy solution to that.

THE COURT: I appreciate there's no ... but what's the practical solution if you have an individual who has no family doctor, can't engage a family doctor, so you keep them on your caseload? Is some ... whoever ...

A. Well, the ... yeah.

THE COURT: ... is prepared to return them to that family of care do they then keep them on their caseload?

A. Often we do keep them on our caseload and then of course that causes downstream problems because that then means that we have difficulties bringing other people into the system that otherwise would receive care because we can't offload some of the patients that don't have a family practitioner if you know what I mean. So the system backs up over time.

THE COURT: It keeps backing up?

A. Yeah.

THE COURT: And so is the system presently backed up?

A. It's certainly backed up in terms of the adequacy of primary care services for clients with mental health issues, that's certainly true, I think.

THE COURT: All right, thank you. All right. Thank you, Mr. Rogers. Go ahead.

MR. ROGERS: No, thanks and we'll get into some of those questions due to access to community care or mental health and addiction services to try to follow up on that in a moment.

THE COURT: All right. Thank you.

MR. ROGERS: But before I get to that component, the second part of the potential delivery of mental health services is through an emergency department, is that correct?

A. Yeah, emergency rooms are sort often a first stop for

individuals in crisis, of course. So sometimes that would include individuals who previously hadn't been formally connected to our mental health services program, so coming into Emergency is often a way for people to access the mental health services that have otherwise not received it up until then.

Q. And so if somebody presents with a mental health crisis in an emergency, what are the options in terms of providing care and what happens to that patient afterwards? And I know you made reference in your discussion earlier whether you keep somebody in the facility or not, what are those options?

A. Well, the role of a clinician in an emergency room setting is a little different than the role of a clinician when they're doing a full assessment. For example, if I book somebody in for a full assessment at one of our mental health clinics that can easily take, you know, an hour and a half or more of your time and then you do other sorts of things and you may see the patient again before you finish the assessment.

In the emergency room setting it's a much more focused assessment. It's focused on what are the immediate precipitants of the reason why the person has come to the emergency department. So that could be everything from, you know, the police brought them in because they're hearing voices, you know.

It could be because they've got a substance abuse problem and they're in crisis related to that, it could be any number of things. But the focus is a relatively narrow one on what could I immediately do for this situation, one; and two, is the situation of such a degree that it's necessary for me to bring the patient into hospital either as a voluntary or an involuntary patient.

Q. And that's what I wanted to get you to comment on a little bit again. So if the emergency room physician says there's a benefit in hospitalization and the two options are the patient agrees to be in the hospital on a voluntary basis, and if they don't then the physician or the psychiatrist has to make a determination as to whether to take steps to do that on an involuntary basis, correct?

A. That's right. So you can offer an individual a voluntary hospitalization and say, I think it would be in your best interest to come in for a period of time and this is what we would try to accomplish over that period of time. The individual patient might agree with that, in which case, fine, in you go as a voluntary patient, which would be the preferred route of admission.

If the person declines to come in then ... or even if they

... in some occasions even if they agree to come in you then have to consider whether or not that should be on an involuntary basis or not and in order to do that you have to give consideration as to whether they meet the criteria under the **Involuntary Psychiatric Treatment Act.**

Q. Right. And let me just divert to that briefly before we continue through the public component system. I know you've made reference to **IPTA** being an area of interest of yours. Generally, can you tell us what the criteria is or what the factors are that you as a psychiatrist or anyone who is a psychiatrist must look at in order to make that decision to make a patient involuntary and have that patient or client hospitalized against their will?

A. Let me preface it by just saying that to bring a patient in on an involuntary basis is something that I always teach the residents that it's not a matter ever to take lightly, right, because it constitutes a very real intrusion in the person's liberty interest to be brought into the hospital against their will, because once they're in then they have very limited sort of freedom of movement, so to speak, so that's an issue never to be taken lightly.

In Canadian law and in most Western countries that I'm

aware of there's two general criteria. And one isn't sufficient. So one is that you have a mental disorder of some description and that's defined in various ways in various jurisdictions, so some define it quite broadly and some quite narrowly. Nova Scotia's is a fairly broad definition of mental disorder.

But in addition to the mental disorder, there has to be some indication of risk of harm to self or others and, again, that's defined in different ways, in different jurisdictions. But in Nova Scotia the ... I used to have this all memorized in my head but I don't anymore. But in Nova Scotia it's along the lines of is threatening harm to self or others or has recently done so and so on and so forth, so it suggests a more imminent risk to harm rather than sort of just a broad category. So more of a recency is of the essence there, so ...

(15:20)

Q. All right. So Section 17, I think, talks about threatening or attempt to ... I can't read my handwriting. Serious harm to himself or others or likely to suffer serious mental deterioration?

A. That's the third clause which is ... there's a psychological or physical deterioration clause which we

generally reserve for individuals where we know that they've got a repeated history, for example, of ... the best example would be somebody who's got a psychotic disorder, that we know that every time they go off their medications if we wait six weeks or so they're going to get ill again. And so that would allow you to bring the person in at an earlier opportunity than otherwise might be the case.

Q. And then is there a legislative-imposed balance required similar to what you say you caution the residents when they're looking at triggering provisions of **IPTA**?

A. I don't know that there's a legislatively-imposed balance, but there's a clinical balance to be struck in that you're always mindful of sort of the potential benefits of bringing a person into hospital against their will, and that's balanced against the potential harms of bringing in the person against their will, particularly as it relates to, for example, ongoing care that that person may receive in terms of whether or not honestly if they come in as an involuntary patient and they leave are they going to show up at your next appointment, for example, that sort of thing.

Q. Right. So now to move out of **IPTA** and go back to the components of the public healthcare system in providing mental

health services. We've been talking about in the emergency context, and I think you likely would have seen the records from St. Martha's Hospital of a visit that Mr. Desmond made to the emergency department that day where he was seen by a psychiatrist, Dr. Ian Slayter?

A. Yes.

Q. And clearly we note from the records that no determination was made that it was appropriate to hospitalize Mr. Desmond at that point, correct?

A. That's correct.

Q. And you have no issue with that position?

A. No, Dr. Slayter had documented a fairly thorough assessment at that time as to what his ... he did have a number of concerns about Mr. Desmond overall but not of the nature that required him to come in as a patient of the hospital setting.

Q. Right.

THE COURT: Mr. Rogers, is that the October 24th or 27 ... I can't remember.

MR. ROGERS: October 24th.

THE COURT: That was October 24th event you're talking about. Thank you.

MR. ROGERS: 2016.

THE COURT: Yes, thank you.

MR. ROGERS: And then I think if I'm recalling Dr. Slayter's notes, one of the things he refers to in the plan is to have Mr. Desmond see his family physician. And then we see that there is the subsequent visit that we talked about earlier to Dr. Ranjini on November 2nd where there is a written referral for Lionel Desmond to a psychiatrist?

A. Right.

Q. So the next component of the healthcare system that I want to talk about is psychiatrists. So we see that referral for Lionel Desmond in to a psychiatrist through the Nova Scotia health system. How does that work? Is it work in the mechanism that I just described of a referral from a family physician or are there other means to get in to see a psychiatrist outside the emergency context?

A. Well, as an individual that's been involved sort of in the senior leadership of the Mental Health and Addictions program, we've done a fair amount of work on this in the last number of years. So we developed a strategic plan a number of years ago which is called Direction 2025, which might sound hopeful but I'm still hopeful we'll get that all together by 2025.

But one of the key components of that that we have gotten into place at this point is we recognized early on that there were a wide array of ways that a person could get into the system, the public mental health system, and ultimately that could be quite confusing to an individual because of those various ways. So we've launched ... it's been a couple of years ago now, though with the pandemic everything of course takes longer to get done, but we now have a central intake system.

So we have a single number that anybody in the province can call and when they call that number they will be in contact with somebody who will do a triage, which is basically a screening interview to sort of get a broad sense of what that person's issues are, and then from that triage they will then make a designation as to whether or not the person needs to come into the public mental health system at all. Because sometimes they may be simple things like distress over some personal issue which doesn't amount to a mental disorder, so that the person may be better served by receiving services at the community level, that sort of thing. But if the person does, by the screening tool, appear to have a mental disorder then they will make a decision as to whether that person needs to see a psychiatrist right away, depending on the nature of the

condition or a general clinician and then they will set a timeframe in which that appointment needs to occur.

Q. So that's a new system that was in place since these events and the tragedies, is that ...

A. Yeah, I can't remember the exact date, but I think we implemented that around 2019 or something like that.

Q. And is that the 1-855-922-1122 number?

A. As far as I can remember phone numbers I think that's it, yes.

Q. Okay. Fair enough.

THE COURT: Can you say that again?

MR. ROGERS: Yes. 1-855-922-1122.

THE COURT: Thank you.

MR. ROGERS: So if your chronology is right that that was put in place around 2019, then would the system in place in 2016 and 2017 in order to access services of a psychiatrist in terms of an assessment and evaluation be through a referral from a family physician?

A. It would have been through a referral from a family physician, but even then it wouldn't have meant that an individual would necessarily see a psychiatrist right away because we found over the years that often, and with all due

respect to family physicians, sometimes they will say this person needs to see a psychiatrist right away, right, for example, and then sort of have a very limited discussion of why they need the psychiatrist so, depressed, needs psychiatrist right away, right, that kind of a referral process.

So in most instances what happens is the person will be seen by a clinician, not necessarily a psychiatrist so one of our other clinical therapists, and then that person will do a more fulsome assessment and then internally refer that individual through to a psychiatrist if it seems like a psychiatrist is going to be needed for either medication management or for diagnostic clarification would be the two most common reasons.

Q. Okay.

THE COURT: Sorry. Can you get to that same spot by calling the 211 number, for instance?

A. I don't ... no, I don't think 211 is ... will get you through to that.

THE COURT: It won't? It won't ...

A. I mean, I think they would probably just give you the number that you've (inaudible - coughing).

THE COURT: That's, I guess, really is my question.

A. Yes.

THE COURT: Will calling 211 with whatever your need is will they pass you through to either give you that number or kind of patch in. So that's just a question I'm going to leave out there. At some point in time maybe we'll get it answered. Thank you.

MR. ROGERS: That's a valid question.

THE COURT: Right.

MR. ROGERS: And then so for Cpl. Desmond I guess we see from the records that on November 2nd he sees Dr. Ranjini who he's described as his family physician, Dr. Slayter. And Dr. Ranjini provides the referral back to see Dr. Slayter, correct?

A. That's correct.

Q. And then if I'm recalling the records correctly, that appointment with Dr. Slayter is set up and takes place on December 2nd?

A. That's correct, yeah.

Q. So that's within a month then of the referral giving rise to Dr. Slayter seeing him and Dr. Slayter agrees that he will continue to see him on an ongoing basis?

A. That's right. Dr. Slayter notes that under most circumstances as is our norm, we try to do things as a consult,

but Dr. Slayter identified that there is some complexities to that case, that he felt that it was wise that he continue on for a period of time.

Q. Okay. So again, if we look at my bullet points of the public system, we've talk about family physicians, we've talked about emergency departments, psychiatrists. What other components are there of the public system that deliver mental health services that we haven't talked about?

(15:30)

A. We have ... depending on the location, we have some outreach services. So in Central Zone, for example, we have a mobile crisis team, but that's not widely available around the province. We have a crisis line which is available around the province now that's manned on a 24-hour basis. So that's another aspect of our strategic plan going forward is to try to leverage technology in a way that we can be more available for people regardless of where they are because getting to see somebody in person isn't always an easy thing to do depending on where you are in the province.

Q. Then I want to talk lastly a little bit about the interplay between those two systems. If a client is receiving mental health services through the private system, even though

they're a resident of Nova Scotia, the Nova Scotia Health system, the public system, may never see them. Is that fair?

A. If they're being seen by a private practitioner, then the public mental health system, we may never see them. We may not even know of their existence, for example, because they wouldn't be on any of our official records. So, for example, if they're in Central Zone and you're seeing a private practitioner, that won't come up on OneContent. So even if I pulled up your name, none of that information will be there. So that's one aspect of it. And our general service delivery model is that if you're seeing a private practitioner, unless there's a reason why you need to see somebody on top of that within the public mental health system, we would not normally provide those services. We would simply refer you back to the private practitioner.

Q. Okay. If VAC is funding services, they're being provided, the Health Authority isn't typically saying, No, you need to get that done through the public system?

A. Yeah.

Q. Okay. Last line of questions are in relation to what you referred to as "the benefit of a warm handoff" when care is moving from one jurisdiction to another or, I guess, from one

care provider to another. And I guess that could arise from all of contexts. Somebody is moving from New York State to Nova Scotia, from Alberta to New Brunswick, and my notes say that when you were asked about that warm handoff if it was to Nova Scotia Health it's trickier to do. And you made reference to a referral system. What were you meaning when you're saying the "referral system"?

A. If you're trying to coordinate a transfer of care from an external agency, whether that's a private provider of care or another organization and our public mental health system, then in order to do that, you have to coordinate those systems. So that, just in terms of time alone, can be labourious in terms of trying to ... if you've ever tried to get everybody's schedule synchronized so that you can have a meeting together can be difficult to do. So that's one aspect of it.

The other is the transfer of information itself because if I'm an individual and I'm receiving care from one organization, unless there's a prior agreement, there's no information-sharing to the other organization unless the patient himself or herself agrees to have that information shared. So then you have to go through the process of requesting that information. And, of course, the patient could say, Thank you, but no thank you. And

then you don't have the right to access that information.

So you can wind up with a number of these scenarios where, just in practical terms, it's difficult to exchange that information, and then it becomes difficult to then coordinate a joint conference, if that's what you would want to call it, to sort of transfer the person's care from one organization to another. So it's easier, within the construct of our public mental health system, simply because we have free access to that information even though, at times, we have to do that by fax rather than through sort of internal electronic means.

Q. And putting your hat on as a general psychiatrist, when you're dealing with a client who comes to you and you're aware that there are records in another jurisdiction that aren't accessible to you, are you aware of mechanisms that you can put in place to either have your patient or you, yourself, take steps to secure those records?

A. I can't think of any specific example other than I know that when sometimes I try to access records from other organizations, for example, like I think I mentioned earlier, CSC, Correctional Services of Canada, there's a process by which you have to request release of those records, and that can take a long time to do.

If I'm looking for records from another province, you run into similar issues related to whatever the law is in that province. So, in some provinces, I can just call up the hospital where I know where the patient was and they will say, Fine, I'll send you the records. Other times, they'll say, Well, no, you have to use a form such-and-such and the patient has to sign it. Then you fax it to them and then the records get sent. So, depending on the jurisdiction, there are various obstacles that you have to overcome to get that information readily available.

Q. And, invariably, it will require client/patient consent to that?

A. In most cases. Again, in part, that's why it's easier within the construct of the Nova Scotia Health Authority because under our current legislation, if you require information from another party within the Health Authority that's related to ongoing care, you can get that information even without the patient's consent, but if it's in private practice, that individual ... the private practitioner won't release those records without the patient's consent themselves. So it varies by place.

Q. Currently, then, within the Health Authority, as long

as they're within the circle of care, you can access those materials without getting patient consent.

A. That's correct.

Q. Thank you, those are my questions.

THE COURT: Thank you. Ms. Miller?

CROSS-EXAMINATION BY MS. MILLER

(15:37)

MS. MILLER: Good afternoon, Dr. Theriault. My name is Tara Miller and I am counsel representing Cpl. Desmond's mother, Brenda Desmond, through her personal representative, Chantel, and, also, I share representation with my friend, Mr. Macdonald, on behalf of Aaliyah Desmond through, again, her personal representative, Chantel, my client.

You've been asked a lot of questions and you've given us a lot of information today. You'll be happy to hear I don't have a lot but there are a few things that I wanted to use your expertise on. I wondered, you know, we went through your *CV* and I think Mr. Rogers alluded to the fact that you had done some work with the military and the Air Force in Greenwood. And that was one of my questions.

You certainly have extensive background, but do you have

any clinical or research work that's specifically focused on a military population as either a general psychiatrist or as a forensic psychiatrist?

A. Not any research work. When I was in general psychiatry, my primary base of operations was in Middleton, so Middleton is, of course, close to the Greenwood base, so I would have had occasion there to see a number of Service members, but I don't have any research background in that area.

Q. Okay, thank you. You indicated, and we've certainly heard this before, that the rate of suicide in veterans and military members is much higher, of course, than the normal population that doesn't fall into that cohort. I think you had said, if I understood your evidence, that the rate in the general population is 11 out of 100,000? Is that correct?

A. It varies a bit from year to year, but in general, in Canada, it's been probably between 10 and 12 per 100,000 per population per year, yeah.

Q. And do you have an appreciation or understanding, Dr. Theriault, in terms of what that incidence rate is per 100,000 regular Force males in the military?

A. No, I'm sorry I don't have ... Certainly, in the Canadian military, I don't have those numbers. I think there's

some work that's been done on that but I don't have that information at hand.

(15:40)

THE COURT: So do those numbers include active service or do they include veterans as well? Do you know?

A. I think there's probably literature on both of those populations but, again, I just don't have the numbers.

THE COURT: All right, thank you. Sorry.

MS. MILLER: And, Your Honour, I don't have the report handy, but there is a 2020 report on suicide and mortality in the Canadian Armed Forces and we can circle back with this through my friends with VAC, but my understanding is the crude suicide rate for regular Force males is 24.5 out of 100,000, and in the Army, which is a branch, 32.88 out of 100,000. So if those numbers ...

A. So you're looking at a rate of two to three times the general population, right?

Q. Correct.

A. Yes.

Q. Yeah. Your report referenced a variety of supporting research papers, one of which we looked at already today and I found fascinating when I was reading it. It's Exhibit 331.

This is, I understand, a book, **Veteran Psychiatry in the US**, and what we looked at was a chapter on military and veteran suicide prevention. Are you aware, Dr. Theriault, of any corresponding research in Canada along the lines of this Exhibit 331?

A. I couldn't say that I do for sure. I know a couple of psychiatrists that have been in the military, but that's more sort of on a personal/professional basis rather than sort of related to any of their specific activities.

Q. Certainly, from our perspective and yours as a forensic psychiatrist, I mean this is a credible resource for you to rely on in your report, correct?

A. Yes.

Q. Okay. And if I can just summarize, it really focuses on the cohort in the US - of course, they have a larger cohort of military members and veterans than we would in Canada - and the significant work that they have done there, both from the Department of Defence and also from the Veterans Affairs group, to really look at risk identification and risk management.

A. They have.

Q. Is that fair to say?

A. That's correct, yeah.

Q. Yeah. And you don't have any issues with the work

that they've done and the research they've relied on, and they're credible, they're evidence-based?

A. Yeah. No, I wouldn't have any concerns with it. I mean it's similar in that regard to some of the information that I reviewed with respect to military services in the UK so, in that sense, I would have no reason to think that the Canadian military services would be significantly different.

Q. And the reason I reference it is because one of the issues we are grappling with and, certainly, His Honour will be left with when writing his report, is recommendations for the future. And, as you've indicated, if I understand your evidence, identifying suicide risk is problematic for a number of reasons.

A. That's correct.

Q. And that's certainly canvassed at page 8 of this exhibit. And, correspondingly, what your advice and experience is is that the area of focus that's actually more material would be on looking at risk management for individuals who have suicide risk factors. Is that a fair summary?

A. Yeah, that's correct. So instead of focusing on risk prediction, which is complicated for a number of reasons that we've canvassed, the interest really is focusing on risk

management in the sense that by effectively managing the risk, you ultimately succeed with the goal which you want in the first place which is to prevent the outcome of concern which is, in this particular instance, suicide, for example.

Q. Of course. And with the lens of perhaps canvassing options for recommendations that don't involve recreating the wheel, if you'll bear with me, I want to take you to page 9. These are some of the things that our American neighbours are doing with respect to identification of veterans at risk. And at page 9, we see something called "Machine Learning". And that is, as I understand it, it's sort of running algorithms based on key words. You'll be better suited to explain it than me, Dr. Theriault. But if I understand this correctly, leaving aside feasibility, if I understand this correctly, that is having some success with picking up veterans who would be at risk. Is that fair to say?

A. Well, you flatter me to think that I might understand this better than you but, certainly, this whole idea of machine learning and algorithms has taken off in the last number of years. So as we've come to learn, there are algorithms for almost anything. So machine learning is becoming an increasingly important tool in these avenues. So, yes, I mean

using machine- learning algorithms to try to parse out some of the key factors that might inform risk is an important part of that. And so this is related to that aspect of things.

Q. Yeah. It may be perhaps aspirational, but, certainly, it looks like it has some positive results, as I understand when I read page 9, the summary on machine learning.

A. Mm-hmm.

Q. Are you aware of any work with machine learning that's being done in Canada, whether in the private sector or in the Veterans Affairs world, to follow or to develop machine learning as an identifier of veterans at risk?

A. It's certainly not something that we're using here in Nova Scotia within the research that I'm familiar with. Whether it's being used in larger centers, I'm not sure. I would expect that, if it isn't, it will soon be, because it's certainly, as I've said, it's an area of tremendous growth in learning and psychology circles at the moment.

Q. Okay, thank you. And if we turn to page 10, Dr. Theriault, this is a second, I guess, initiative that has come out of this vast body of research and work by the Department of Defence and Veterans Affairs in the US, and its heading is "Implicit Cognition". Are you familiar with that method of risk

identification?

A. I'm only peripherally familiar with it. I'm familiar with the general idea of using reaction times to gauge people's responses to things, but I'm not as familiar with it in the context of this particular research.

Q. Okay.

A. It's an area that we've used in sexual offenders, for example.

Q. So you've seen this used, implicit cognition, with sexual offenders in Canada?

A. Well, particularly as it responds to reaction time to sort of visual images for individuals who are sexual offenders as a way to gauge their sexual interests and things, for example.

Q. And so this is a method of treatment, or a method of determining suicide risk with respect to, I guess it arises out of veterans. And it looks like, if I understand again, that this has had some success as well in its use and in the studies with it. Is that fair to say?

A. Yeah, that's fair. From that literature base, yeah.

Q. And outside of the use of implicit cognition with sex offenders, are you familiar with any of this kind of work -

implicit cognition - that's being done in Canada or in Canadian Forces or Veterans Affairs?

A. I'm not, no.

Q. Okay. I'm moving now from risk identification into the items that have been identified. I'll call them "risk management". And that starts at the bottom of page 10. We see "Crisis Intervention for Suicidal Veterans". And then we have a "Crisis Hotline and Online Chat". And, certainly, we've heard evidence that those resources definitely exist in Nova Scotia and across Canada. If I can take you to page 60, we see "Safety Planning". And you've already given your evidence, Dr. Theriault, on this. This is what you were talking about that you actually implement. Correct me if I'm mischaracterizing your evidence, but that within your work, it's a binder of resources for individuals. It's done collaboratively.

A. With the client and with collaboration of the people that may be a provider of assistance to the individual, that's correct.

Q. Correct. And it's more labour-intensive, if I'm understanding it correctly.

A. It is because you have to sort of work with the person to sort of understand from them what they might think are the

most critical factors that would be helpful for them in a crisis.

Q. Yeah.

A. And then you have to really engage that party to make sure that they feel comfortable, that they are going to be available to the person if such a crisis occurs, because it's of no use to say, Well, I'll call my Uncle Bobby if Uncle Bobby won't answer the phone when it comes through ...

Q. Right. And then on page 12, this is a third item that they've been using with success, as I understand it, and it's called "Crisis Response Planning", and it says:

> A crisis response plan is a variant of the safety plan approach that has been used in cognitive behavioural therapy for suicidal individuals.

And then it goes on to say in the second paragraph:

> At it's most basic, a CRP consists in a list of reasons for living or a survival kit of hope-inducing objects. A commitment to restrict access to lethal means, contact information for emergency resources; example, suicide hotline and information

regarding a specific emergency department that can be accessed.

It goes on to talk about:

Basically, this information is reduced to a card that individuals can take with them.

Are you familiar with this concept from your research in preparing your report for the Inquiry, Dr. Theriault?

(15:50)

A. Well, I'm certainly familiar with it as a general concept that it wouldn't be unusual for ... primarily in my work that I've done with suicidal individuals in the civil sector, that we would develop some sort of a similar mechanism and they would carry that with them as sort of an aide-memoire, so to speak, should they find themselves in a crisis.

Q. So a little card that the individual can carry on their person for their quick reference when needing it is how it's described.

A. Right.

Q. And the reason I'm focusing on this is because I haven't seen anything along those lines, through my review of the documents, that would've been a tool for Cpl. Desmond. And it also, at the very last paragraph, says:

> The research concludes that the crisis response planning could be an especially valuable tool as its easy administration requires less expertise and time. As such, it may reduce the workload of overburdened service providers in both the short term and the long term; example, through reduced inpatient admissions.

So I read this as thinking that that might be a very low-hanging fruit, perhaps, in terms of something that could be actioned for individuals who have been identified as at risk for suicide. Would you agree with that?

A. Yeah, I think that would be a reasonable thing to do. I mean, I suspect, although I don't know for sure, that in Central Zone, we have a short-stay unit where, often, we will admit individuals for brief periods of time when they're in crisis. And part of the work that would be done with a patient during that period of time would be to develop this kind of plan. Whether or not they then produce it as sort of a take-home card or not, I don't know, but it certainly would be something that could easily be done.

Q. And through your review of the records in connection

with drafting a report, did you see any evidence of Lionel Desmond having a crisis response plan similar to what's outlined at page 12?

A. I didn't see anything specific to that. I did see that, when he was at Ste. Anne's, he had what was referred to as a "coping card", but I don't know if that was the same thing in the sense that I think it was, from my read of the material, it seemed to be more of a coping card that would be related to, How do I cope if I'm feeling emotionally dysregulated? How do I calm myself down? You know, breathing techniques, all those sorts of things, but not sort of a more elaborative process where he could look at it and say, Well, I'm in crisis now. Who do I call? How do I get ahold of them? What do I do? That sort of thing.

Q. Okay. I'm going to move from that exhibit, Dr. Theriault, into just some general concepts. You know, one of the things that I think we are all struggling with is the balancing of information sharing; and, certainly, as you reviewed, there were various buckets of information that followed Cpl. Desmond throughout his time both in the military and discharge from the military and then transitioning back into civilian life.

You indicated earlier that, certainly, information from prior treatment can provide helpful information. A quote I have from your evidence: "It's important to know the chronicity of symptoms, for example, because that informs treatment." And then you said, you know, "Useful information also has to be meaningful." And I wanted to drill down a little bit more with you in terms of what you believe, in the context of Cpl. Desmond's situation, would've been meaningful information that could have been moved forward from those various entities and providers with the understanding, of course, there's a vast amount of information.

A. Yeah.

Q. But you made a distinction between useful and meaningful.

A. Well, I think that, in my thinking about that, that in the course of therapy with any individual, you amass, as you said, a considerable amount of information, and that information, as it goes forward to another clinician, can be useful in the sense that it gives you a context of the person and your sense of some of the background information of the person so that when you meet them for the first time, for example, if you're a new therapist, that you have some sort of a

priori expectations of what you might see, but there are pieces of information that are more meaningful and necessary in the sense that they're a more, you might think of it, a concrete distillation of some of that information that allows you to say, Okay, this is the information that I have available to me that suggests that this is a major focus of intervention that I need to understand. And so that information becomes the crux of sort of not only just getting to know the person, but understanding what treatment interventions you might need to apply. So, in that sense, they're complementary but somewhat different, I guess.

Q. Thank you. So that's generally, but are you able to tell us specifically what pieces of information would have been - the meaningful pieces of information that would have been most germane for moving forward from the Canadian Armed Forces to the Veterans Affairs to when he goes to Ste. Anne's, when he comes out of Ste. Anne's. Are you able to do that exercise? What would've been the most meaningful pieces of information? And when we read your report, I mean you've had the ability to go through and pull all those things out and read it in a concise fashion, but are you able to tell us now what you think would've been the most meaningful information, in hindsight, relative to

... is it those pieces of information that are in your report?

A. Well, I think it would've been information in some of the domains that we've had under discussion over the last few days. So, you know, information related to what are the symptoms of his PTSD? What symptoms are paramount and what are most prominent in any particular time? What have been the biggest issues for him with respect to PTSD? Issues related to, of course, his social environment which was an ongoing concern for Mr. Desmond over time, and sort of who are the key sort of figures in that and what are some potential thoughts about how to intervene successfully in that situation. And then, more broadly, other social situations like ... inasmuch as they form the background against which therapy works, you know, social situations around stability of housing and finances and all those sorts of things which aren't really part of therapy, but they're critical for success in therapy if they're not there, certainly.

Q. Right. They're sort of social determinants of health ...

A. Yes.

Q. ... that are interwoven with setting somebody up for success.

A. That's right, correct.

Q. You talk briefly about collateral information from family members. If you can get that, how important is that, from your perspective, Dr. Theriault, in terms of being able to fully inform a treatment provider and set them up for success moving forward?

A. Well, we certainly try to support families in therapy. So we like to think of therapy as not just person-centered but family-centered but, of course, that has to take into account as well the independent wishes of the person involved themselves. So although we generally, in therapy, would want to sort of have some engagement with significant support figures, that requires some discretion on the part of the therapist and discussion with the client themselves as to what the extent of that information would be and how that information gets shared, but, certainly, as much as possible, we like to think of mental disorders as affecting the whole family and not just sort of the person in and of themselves, so to try to involve family as much as the person is comfortable in allowing us to do so.

Q. Yes. And if you are allowed to do so. And particularly with the lens of suicide risk and domestic violence, do you see a system where there would be actually a

heading in a discharge report or an intake report, or both, that would be a place that you could capture and preserve that type of relevant collateral information so that it can be passed on to next treatment provider, so it's gathered, it's preserved, and it's shared?

A. I mean certainly when we do admissions at the hospital, the standard form that we use has a category of social supports, for example. So that would be, for example, a place where you could capture who the individual social supports are and what their relationship is with those social supports; perhaps contact numbers and those sorts of things. So that could certainly be put in a discharge summary to be made available, for example, for people post-discharge from hospital in those situations.

Q. So I'm hearing you say that the people's names and their numbers would be available, but what about the detail that they might provide you? And, I think, in this case, we do know that there certainly was information provided at various times, and certainly at Ste. Anne's, by Shanna Desmond about the magnitude of the anger and the fear that she had.

A. Mm-hmm.

Q. And that didn't seem to make it into any kind of, I

guess, a category in the discharge report. So that's my question. Do you see value in structuring reports in mental health that specifically have a heading that addresses potential risk factors for these things - domestic violence, suicide risk - so that it can be carried on with the collateral information?

(16:00)

A. Yeah. No, I think that that would be a very useful sort of a tool and piece of information to have because ... you're right. You need to be careful not to just look at the person through one lens, but you're looking at the person through, not just another lens, but sort of a different lens that sort of lends another sort of piece of information that might be important in terms of managing risk going forward based on not only what the individual patient says but what the other person says.

For example, we know in the ODARA, if you're familiar with that instrument, that the potential victim's own expressed concern about their safety is an item on the ODARA checklist in terms of risk assessment for potential violence.

Q. Thank you. I want to move now, briefly, to ... you talked about successful treatment and certainly it was evidenced with Dr. Rogers and there were three factors: consistency; the

rapport she had with Cpl. Desmond and that she was using evidence-based treatment; and that that, you know, really, that successful treatment then can be carried forward or enhanced with a warm handoff to somebody who has an appreciation of the background. And I think you said that's even more important for somebody with earlier traumas that create difficulty with them trusting the motives of others. And that certainly was, I think as you've identified, Cpl. Desmond would've had some of those earlier traumas which would have provided him with a level of mistrust, perhaps, of future treatment providers. We see that towards the end, certainly, of his stay at Ste. Anne's.

A. That's some of the information we have, that's correct.

Q. Yes.

A. Yeah.

Q. I was curious, Dr. Theriault, about your take on the impact, if any, on Cpl. Desmond for having to tell his story - if I can use that sort of phrase - telling his story over and over again from October 24th of 2016 when he showed up at St. Martha's emergency department room. And so my friend, Mr. Rogers, and I took you through all those points of entry into the health care system, but there was an emergency room visit on

October 24th that he sought out, and November 2nd, he goes to the Guysborough emergency department. That results in, of course, the referral, and he has to tell his story there. December 1st, he goes to St. Martha's. We know he waits there for a period of time, but he eventually leaves after three or four hours because he's not seen. He leaves on his own accord.

A. Mm-hmm.

Q. He sees Dr. Slayter. Then, at the end of November, he meets up with his clinical care manager, Helen Boone, for the first time. He has to tell her his story, or at least start to tell her his story, and then he starts to see Catherine Chambers in and around that period of time. So those are like five to six, I guess, entry points into treatment where he has to start from scratch, effectively, because there are no records that have been able, generally speaking, you know, gathered, preserved, and shared.

A. Mm-hmm.

Q. What's the impact, if any, from your perspective on somebody like Cpl. Desmond in setting him up for success through those treatment points?

A. Well, at a minimum, it can be extremely frustrating. As I was mentioning, we've gone through a strategic review of

our mental health and addictions programs and one of the things that came forward in our review of that was how frustrating patients find it when they have to give their story several times over before they get into a treatment program, because it can be seen by the patient as belittling or humiliating to sort of have to tell the same story over and over again. So, at that level, it can, at a minimum, be frustrating.

For somebody like Mr. Desmond, who I think had general issues with trust in the sense of who he could trust and who he shouldn't trust, having to tell that same story over and over again would potentially exacerbate those kind of features because I've had the experience lots of times, when I've tried to elicit a story from somebody, they would say, Well, didn't you read the record? Don't you already know that, sort of thing? So it can undermine the person's trust in the care provider at a time when it's critical really to try to make that rapport relationship.

Q. And from what you've just shared - and it was going to be one of my questions - is it fair to assume that patients would assume, given that they've had a long history of mental health contact, that the person they're now seeing should have some of that, that they may just assume and maybe not even

disclose everything because they assume you have it all? Is that a fair assumption?

A. It's fair. There is a balance to be struck. So, on the one hand, it's useful to have that information. Of course, every clinician will want to do their own independent assessment, so that does mean that you do have to revisit some of that material over again, but a person will often preface it by saying, I appreciate that you've told this story before and so I'll just focus on those areas that I'm particularly interested in to try to avoid, sort of, recapitulation of the entire story.

Q. But if you're starting from scratch with no records then you have to start from scratch as a treatment provider.

A. You don't really have a whole lot of choice there, yes.

Q. Yeah. You talked about - and maybe I didn't get it right - DRAG and VRAG? These are, I think, assessment tools?

A. Yes.

Q. Okay. And DRAG is for domestic violence?

A. Domestic Violence Risk Assessment Guide.

Q. Right.

A. VRAG is the Violent Risk Assessment Guide.

Q. Right. And I understood you say that the VRAG, the Violent Risk Assessment Guide, somebody had to already have committed a violent act to then have that applied to them? Is that correct?

A. That's right because having committed already one violent offence of some nature, that means that we know that the probability that they will commit another one is already at a higher rate that makes it possible to use actuarial tools to produce probability scores..

Q. 30 percent higher, yeah. And is that the same with the DRAG, that in order for that domestic violence risk assessment tool to be applied, the person has already had to have been ... I guess there has already had to have been a known event of domestic violence?

A. That's correct.

Q. Okay, thank you. And then my last question for you, Dr. Theriault. My friend asked you this morning, he said, you know, If you had been treating Lionel Desmond in August of 2016 and you were aware of the homicidal thoughts on a daily basis and the borderline paranoid personality traits, would you have flagged this? Would this have been a concern to you? And if I understood your evidence, you said yes, you would've flagged it.

And my follow-up question for you, Dr. Theriault, is you would've flagged it and then what? What would you have expected if it had been flagged would've happened? What would've been done with that?

A. Well, ideally, having flagged it, I would've then given some thought to, well, are there particular components of his presentation that might be better suited to therapy by another clinician? Assuming that we, within our public mental health system, we generally work within a team; so, for example, I might consider whether he ... in this case, Mr. Desmond would've been referred to a psychologist for ongoing therapy at the same time that he was seeing me as a psychiatrist, assuming that I was focusing primarily on pharmacological approaches of care or something like that, because we've had some discussion about any cognitive limitations that Mr. Desmond may have had, whether a more fulsome occupational therapy assessment related to some of his functional capabilities might've been indicated at that point. So it would depend on sort of the different findings at the time, but involving other team members, essentially, in his overall care of service.

Q. Specifically with the homicidal thoughts on a daily basis, would there have been anything you would've done to

address those?

A. I think that would've led to a discussion with Mr. Desmond about, regardless of whether or not he felt that that was not something that he would do, that it would ideally be in his best interests to make sure that he didn't have any lethal methods around him in case his resolve in that matter. And it didn't state where he said that it was. And that might involve ... ideally, that would involve, because it's ... you could, for example, as we've talked about, simply take the word of the individual and say, Okay, I've gotten all the weapons out of the house, but you'd have a lot more comfort if you could contact somebody else and say, you know, Go with him and make sure all of the weapons are out of the house and keep them somewhere else or something like that, for example.

Q. Okay. Thank you, Dr. Theriault. I appreciate your time.

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

CROSS-EXAMINATION BY MR. RODGERS

(16:10)

MR. RODGERS: Thank you, Your Honour. Thank you, Dr. Theriault. Dr. Theriault, I'm Adam Rodgers and we've met before

virtually, good to see you again. I'm representing the personal representative to Cpl. Lionel Desmond, his sister, Cassandra, and so I want to thank you for your report and your testimony. It's certainly an interesting line of work.

Dr. Theriault, I've listened to the totality of the evidence throughout this Inquiry. Some themes have ... sort of preliminary recommendations at this stage seem to be emerging and I want to review some of them with you this afternoon. And these are some topics that have been raised by Dr. Joshi, Dr. Njoku, Dr. Ouellette, Dr. Gagnon, and observed by others; discussed by Dr. Rudnick from the OSI Clinic in Halifax. I'm not sure if you're familiar with Dr. Rudnick.

A. I know Dr. Rudnick, yes.

Q. You would know him probably.

So it seems, Dr. Theriault, that a complicating factor in the treatment of Cpl. Desmond was that his form of PTSD did not seem to respond well to traditional treatment modalities, and it seemed like perhaps he didn't have the basic version of PTSD; but, rather, perhaps PTSD with dissociation. So I want to talk to you about that but, first, I guess you would be aware that PTSD with dissociation is a recognized subtype under the DSM-V?

A. It is. It was included in the DSM-V for the first

time as a subtype, that's correct.

Q. Yeah. Well, it seems to be an emerging field of study where it's new to the DSM Guide, from some of the other evidence we've heard. So I just want to go through some of what we've heard in the Inquiry so far with you.

Dr. Joshi just introduced it, talked about, or testified, that dissociation is where a person might lose track of reality and start to behave as if the traumatic situation is recurring and might take actions as if they're in the situation again, and that such an episode might be triggered by something that reminds them of the traumatic event and then it somehow causes certain memory circuits to get activated.

So that was Dr. Joshi's view of dissociation. But, just stepping back, I want to talk about Dr. Wendy Rogers' treatment, and I think you correctly identified that she seemed to be quite successful in her treatment of Cpl. Desmond at least for the time when she was treating him, but she also mentioned that post-traumatic stress disorder was the most prevalent diagnosis for troops released for medical reasons. Would this be an area where you would be familiar as well, Dr. Theriault, in terms of just why soldiers would be released for medical reasons and the prevalence of PTSD?

A. I'm aware of the general prevalence of PTSD in military populations. I'm not as conversant with what are the other sort of psychiatric diagnoses that sometimes lead to being dismissed from military services though because I don't work in military services.

Q. No, that's fine. And Dr. Rogers also said that because it's prevalent, and so prevalent, and because, of course, we're going to have future missions, presumably with our military being active, that it's important to get this stuff right and, I guess, demonstrate to the public and to Canadians that we're getting it right so that recruitment doesn't suffer as a result of people thinking, if they go into the military and engage in any combat activity, they may suffer this kind of fate of an unknown, untreatable situation.

So that's what I want to ask you a little bit about, Dr. Theriault, and just to, I guess, talk a bit about it. The US Military Veterans Affairs website, and we've seen some of the US research and data today and throughout the Inquiry, says that dissociation ... sorry, studies show that 15 to 30 percent of individuals suffering from PTSD reported symptoms of depersonalization and derealization, which are sort of elements of dissociation. So it doesn't seem like it's that rare of a

situation. Would this be anything you're familiar with from your research or from your review?

A. Yeah, it's consistent with sort of the literature that I've reviewed in terms of its frequency and its presentation. That's correct.

Q. The US Veterans Affairs site says that those who had those symptoms are more likely to be suicidal and have functional impairments and that treatment ... so far, the treatment of it has been through cognitive restructuring treatment and skills training in interpersonal regulation. Those strike me as very intensive treatment modalities and things that take you a long time, or at least an intensive experience, with the patient.

A. Well, they certainly could. So, for example, Dr. Rogers, I think, saw Mr. Desmond on a weekly basis for the period of time that she followed him.

Q. It seems perhaps that, you know, the treatment that Dr. Rogers was providing to Cpl. Desmond was successful for a time, but then there was an incident, a workplace incident, involving the chocolate milk comment. I'm not sure if you're familiar with this. It was about six months after she had sort of discharged him and then that seemed to retrigger his PTSD and

bring him back into treatment, maybe not at square one, but it brought him back a considerable distance.

A. Mm-hmm.

Q. So, in a way, her treatment, though successful, was only temporarily successful, and it seems possible that a dissociation diagnosis may help explain some of why that was the case.

So I just want to go through a few of the other doctors and their comments. Well, before that, you've already touched on this, and this was the incident where Cpl. Desmond woke up and he was choking Shanna, his wife, in bed and emerged from that. We heard from Shanna's brother, Sheldon, who was actually in the house at the time, where he was staying with his sister and Cpl. Desmond in Oromocto, that he heard his sister yell, Lionel, and Lionel Desmond came out of the room, he was in tears. He was very shaken up by what had taken place, walked downstairs and, you know, from thereon, or at least for a time, slept separately from his wife, I think, to avoid a recurrence of that.

A. Mm-hmm.

Q. So that strikes ... seemed to be a dissociative episode of some kind.

And then there's Dr. Njoku who worked with Dr. Murgatroyd

at the OSI Clinic in New Brunswick. And in his report, we don't need to bring it up, but it's Exhibit 244. On page 30 of that report, he says that Cpl. Desmond indicated that he experienced dissociation episodes most of the day. And then on page 34 of that report, he said that Cpl. Desmond had a few dissociative episodes. So there was reports of this with Dr. Njoku while Cpl. Desmond was in New Brunswick, and when he testified, Dr. Njoku said that these dissociative episodes would be like an extreme reliving experience in the sense that he would have a vivid image or a vivid recall of the trauma event and then you'd be acting out the trauma. So the way Dr. Njoku described it is you'd be located physically in one place, but your conscious awareness would be located in the place of the original trauma. So, in Cpl. Desmond's case, he may be in New Brunswick but responding to a person as though they're a staff sergeant or a Taliban member. Is this consistent with what you've read on dissociation?

A. Well, it's certainly consistent with what the literature would refer to as a "flashback". So that's sort of essentially the definition of a flashback. A flashback is a dissociative event.

Q. And so Dr. Njoku identified that a complicating factor

of that is you would normally treat PTSD through exposure therapy - re-exposing them to the traumatic incident - but, in this case, you know, if it's a dissociative episode, that may just exacerbate the situation by having that exposure therapy. So, therefore, it means you have to work that much harder on the patient and on the situation to actually treat it. And, you know, so if Cpl. Desmond was having one of these episodes that he would be, you know, like maybe talking to a person in front of them, but calling out the name of an assailant or, you know, something from the original traumatic event. So that was Dr. Njoku who treated Cpl. Desmond in New Brunswick.

(16:20)

Dr. Ouellette, who was a psychiatrist at Ste. Anne's, the facility in Montreal, also talked about dissociation, and he had observed an episode in his office with Cpl. Desmond, but he talked about it as these flashbacks. He says he's not himself. He's over there in Afghanistan. So he said, Where it's a person feels out of body and not in control, feels that things are not real around him because of anxiety. And, you know, again, Dr. Ouellette said that people would act out as though they were back in a war situation and take out violence on somebody that might, in their mind, be a combatant but, of course, in reality,

not be. And, in fact, Dr. Ouellette identified a separate client of his that had driven 300 miles in a dissociative episode and, of course, a 300-mile drive takes quite a long time.

So it strikes me, Doctor, that there may be some unknowns about this field, particularly if what Dr. Ouellette says is accurate and somebody could drive that kind of a distance under an episode. Now he didn't say ... he didn't observe that length of an episode in Cpl. Desmond, but in others.

I guess what do you think of that?

A. There are a number of issues at hand related to dissociation in general so it is, as you've said, it's part of the current diagnostic criteria for PTSD, but, as I understand those two concepts of derealization and depersonalization, they're dissociative events in the sense that the person feels removed from themselves, in a sense, so that there's a sense of being separate from yourself or that things around you seem unreal or that your presence in the world is somehow changed, but they're not dissociative in the sense that we would anticipate, with an event like dissociative amnesia, for example, where you're amnestic for an entire episode of things that happen to you. So that's a distinction between

derealization, depersonalization, and dissociation more broadly. And what literature I could find on the phenomenon of a flashback, which is of particular interest because it is a dissociative event, is that they are relatively short-lived events. So the issue really becomes in the context of what happened on January the 3rd to the degree that dissociation could potentially form an explanation for the chain of events that occurred on that particular date, right? So that's ...

Q. And I'll bring us forward to that shortly because I want to review some potential theories on that timeframe. The last one was Dr. Gagnon who is the psychologist at Ste. Anne's who had also identified some dissociation with Cpl. Desmond; a loss of control, experiencing sensory reminders of his deployments, but she described it as "a continuum". So if it's recurrent and persistent enough to require individual clinical attention, or if it's something less than that that can be dealt with in a normal course of treatment.

So Dr. Rudnick, Dr. Theriault, was, I think, a pretty well-respected witness here as well on all kinds of topics really, but one of the things that we talked about was dissociation. And he agreed, I guess, with Dr. Njoku that that dilemma existed where, normally, you would treat a PTSD patient through exposure

therapy. Maybe the EMDR Rapid Eye Movement ...

A. Desensitization.

Q. Primarily through exposure therapy, but that that was again potentially exacerbating a problem if it was PTSD with dissociation. And he identified that some of the ... Of course, you know, I think we know that Cpl. Desmond didn't receive any specific treatments for PTSD with dissociation, or it's not clear that he did, in any event. But Dr. Rudnick said that, in extreme form, that would be a fugue state where a person is found in another place, doesn't know how they got there, or a split-personality disorder. But the more moderate form is what we're talking about which is the depersonalization/derealization. And Dr. Rudnick said that a psychotherapist would work with the person on grounding techniques.

A. Mm-hmm.

Q. And that that would be a way to at least stop an episode or short-circuit it if it's occurring and the person realized that it was occurring. So there's some progress being made there. Would that be something you'd be familiar with, Dr. Theriault?

A. Yeah. No, that would be a general approach to sort of

those kind of events that you attempt to get the person to ground themselves by focusing on their five senses and trying to get them to place themselves in their current situation rather than the situation that they may feel that they're in.

Q. Sort of snap out of it. You know, when I hear Shanna's brother, Sheldon, talk about, you know, her yelling, you know, Lionel, you know, to snap him out of it and bring him back to reality, that seems like a form of grounding - an external form of grounding.

A. Mm-hmm.

Q. But a form, nonetheless. Dr. Rudnick also said that there's no medication for this specific to PTSD with dissociation.

A. That's correct.

Q. That familiar as well? Okay. So another difficulty with the condition is identifying what might trigger a dissociative episode. And Dr. Rudnick testified that it could be anything and it may be different for different people. And so would you agree, Dr. Theriault, that that is an additional difficulty in treating ... We're thinking specifically of combat veterans here, or veterans with PTSD with dissociation, that it may be a certain smell for somebody, a certain visual

for somebody else that may be a different trigger, and that's a further complication.

A. Yeah, it's unique to each individual, so it depends on sort of the original trauma and what are the cues that might remind you of it. So it could be sort of something fairly obvious like loud sounds, but I've had individuals who would say that certain music that they hear would bring it on simply because it reminded them of sort of the environment they were in around the time that the event occurred, for example. So it's very individual to the person.

Q. And I'm not asking you the questions in order to sort of test your education on the subject. I suspect you may not have particular expertise, although you're certainly familiar with it, Dr. Theriault, but the question, I guess, would emerge from this is would you think that this would be a good area for further study perhaps by the OSI Clinic which is going to be treating military veterans, or the health system more broadly? I'm not sure. What's your view on that?

A. Well, certainly, inasmuch as it's a recognized subset of PTSD in the current DSM-V, it would certainly be a ripe area for exploration for research. I would agree with that certainly.

DR. SCOTT THERIAULT, Cross-Examination by Mr. Rodgers

Q. Now I want to talk a little bit now about January 3rd, 2017, and I know we have your opinion, Doctor, but I just want to consider, if we think that dissociation may have played a part in this, where that may have been, how that may have manifested itself. So we'll look at a few timeframes.

So Cpl. Desmond returned from Leaves & Limbs, where he purchased the firearm, to the Greencorn residence - his aunt and uncle's place - around, say, 5:00 or so on the 3rd. That's where he changed into his camouflage clothing, switched vehicles, drove into the woods with his newly purchased rifle. So at that time ... Now that may have done with some intentionality or it may have been the start of, or part of, a prolonged dissociative episode.

(16:30)

So I want to step back a little bit and review a few things with you. So we know that he was at Leaves & Limbs between 4 p.m. and 4:22 on the 3rd. And so just first of all, late December/early January doesn't seem to be a sensible time to be purchasing a firearm; it's not near hunting season, which has just started. So that's one thing. And, you know, we've seen how calm he was on the videotape as well. The owner testified, and Dr. Rahman testified, how calm Cpl. Desmond was while he was

there, and the owner, in fact, knew Cpl. Desmond from previous visits, and we've seen the video, like I've said. Very patient customer, waiting his turn, and he was unhurried, unagitated.

And so you look at that time - where it's so close to the tragedy itself - for some signs of what may have been to come; whether it's signs of planning or deliberate deception. And it seems, if you were just an onlooker, that you may not notice anything unusual about his behaviour there.

But let's start with the knowledge - and we've talked about this already with Mr. Russell - that Cpl. Desmond knew firearms. He was in the military. He was somewhat of an expert with respect to firearms. And so you would assume he'd be aware of some of the different kinds.

Now he bought this SKS rifle and there were similar models there to what he actually purchased, but he purchased a used model, not a new one. So you'd think, okay, price is a consideration normally, but if he was planning to do what he did, maybe price wouldn't be an issue, or why would it be? That seems like a curiosity.

Another unusual feature was that Cpl. Desmond spent some time looking for and looking at storage cases for his rifle. Again, given what actually took place, there doesn't seem to be

any need for a storage case for any reason. The gun came in a box and that was legal for transportation.

And then we've already talked about the bullets that he purchased; the more expensive rounds rather than the surplus ones. Saved 35, $40 by doing so. And then he purchased a firearm with a scope. And, again, that doesn't seem to make sense when you consider what actually took place, and would have been completely unnecessary considering, again, what happened. So some unexplained behaviours in purchasing decisions there by Cpl. Desmond.

So, you know, if his intention was to leave and go kill his wife, well, all he needed was a very basic rifle and basic ammunition, but what he did buy seemed more in line with somebody who knew what they were doing and legitimately seeking a firearm for hunting. A good used rifle. Good ammunition. With a scope. He spent his money wisely.

I mean what does that say to you, Dr. Theriault?

A. We'd had some related discussion about this this morning really and I indicated that that really is sort of one of the key nexus points in this whole issue is that, in some ways, some of Mr. Desmond's behaviours on that date were forward thinking, but that was all said in the context of an individual

who had had ongoing difficulties in his relationship and had had, just within the several days before, not one, but, if you want to think about it, two crises in terms of that relationship, both in terms of the event that occurred on New Year's Eve and then sort of the arguments that ensued after that, including his wife's final comment to him that he reported to his therapist that she was finally going to leave him. So that creates a number of questions, of course, that the Inquiry will have to attempt to answer.

So you're not wrong on the one hand that many of the things that he did would seem to be reasonable things to do; although, as you said, it's kind of a weird time to buy a firearm but, at the same time, they would also be things that one would do if they had a more basic motive in mind which would be, you know, the killing, ultimately, of his wife.

So what it suggests to me is that - the best that I could come up with - is that, as is the case when we discussed suicide that it may be that right up until the last moment that Mr. Desmond was ambivalent about what, in fact, he was going to do with the purchases that he had acquired leading up to the events of January the 3rd.

Q. Some other future-oriented decisions or steps that he

had taken around that time. One was he got medical attention in December on a cut finger in Guysborough from Dr. Ali. Going to see Dr. Slayter itself and then scheduling his next appointment, looking for an apartment, searching for a gym membership, contacting Antigonish Family Resources, and actually returning a pair of boots that he bought online.

So some thoughts are, if Cpl. Desmond was planning to commit homicide against his wife intentionally, that perhaps dissociation kicked in or was triggered by that itself, or the pressure of the moment. So that seems to be one possibility. Perhaps we can't know these things for certain, Dr. Theriault, but that would seem to be a stressful, pressure-filled moment for anybody, including somebody like Cpl. Desmond who had brain injuries and cognitive limitations.

There's another possibility which was the social worker at Ste. Anne's talked about a fear of abandonment, and I'm not sure if you've seen this in some of your cases, Dr. Theriault, but what Ms. Hamilton suggested was that Cpl. Desmond may have had a fear of abandonment and then would put pressure on his wife to reassure him, and that maybe this was somehow a manifestation - an extreme manifestation - of that fear of abandonment; showing up with a gun and saying, We've got to get back together,

putting that kind of pressure on her to say yes or something. Is this something you've ever seen in any of your cases?

A. Well, sadly, I've certainly seen cases where it comes down to that sort of ultimate showdown, so to speak, you know, which is, you know, If you won't come back to me, if you won't repair the relationship, then the scenario is, Not only can't I live, but you can't live either because I can't have you live without me. So I've seen that sort of scenario act out over the years.

Q. Because on January 1st, New Year's Eve, you know, he went to the hospital. He said he needed a place to sleep for the night. Well, he had another place to sleep. He could've gone to his aunt and uncle's place, but he went to the hospital. His wife had asked him to go, I think, and as soon as he got there and was admitted, he was texting her to tell her he was at the hospital. So there's the potential that he was there to sort of show her and demonstrate to her that he was willing to make his changes and become a different person and get his treatment but then who knows if there was further discussions on that topic?

Another possibility, Dr. Theriault, was being in the gun shop itself. Now Dr. Rogers suggested that going hunting or

being around firearms may actually be a different form of exposure therapy and might be soothing for somebody in this situation but, again, it's a gun store, and camouflage and, who knows, that imagery and just being in there may have had some effect on him. Would you be able to say anything about that possibility?

A. Well, certainly, he was an individual that was familiar with weapons, so whether or not that acted as either sort of a mitigating factor to make him feel better or, on the other hand, make him feel worse, it's difficult to know. I don't have enough information about that. I mean we all know that it's one of the critical junctures in this particular incident, that he was at that gun shop on that date and was able to acquire the weapon, of course, which is an issue, in military culture, of course, in general, that a person's ability to continue to have the rights to their firearms is often an important value for them.

(16:40)

Q. Yes. And, of course, that's an issue in itself that we're dealing with as well in the Inquiry, Dr. Theriault.

So another curiosity related to that about Cpl. Desmond's movements that day. Okay, so at 1 p.m., we know he was at the

hospital, at St. Martha's in Antigonish, and then at 3 p.m. when the school bus arrived back in Lincolnville, he was seen leaving, and we know he went back to Antigonish at that point to go back to Leaves & Limbs, so it raises a question as to when Cpl. Desmond decided to buy this firearm. I mean we have some internet search history that suggests he was looking for one, but if he had been planning to purchase a firearm that day, or even a few hours before, he was already in Antigonish. He was in Antigonish to book his appointment, drives back to Lincolnville, 35, 40-minute drive and then turns back around and goes straight back to Antigonish to Leaves & Limbs. So it seems possible that perhaps only on the drive home that he made this decision, or right after 1:00 and he booked the appointment was when he spoke to his counsellor, Ms. Chambers, as well, and had that sort of disjointed telephone call that she described.

So do you have any thoughts on that as to, you know, whether a phone call with a therapist could be a trigger, or anything ... he had to pass by his wife's home on the way back to his aunt and uncle's place, whether something like that could be a trigger, because he drives back from Antigonish and then turns around and goes back to Leaves & Limbs which is just outside of Antigonish.

A. I mean, for me, not knowing Mr. Desmond personally, I don't have a clear inventory of what, for him, were constituted as triggers for him. To me, a lot of this is ... I mean I'm sure you've heard of "Occam's Razor", right?

Q. Yes.

A. Simplest explanation with ... So as a forensic psychiatrist, if I use Occam's Razor on a situation like this, I don't know what some of the interceding events were that led up to the actions that Mr. Desmond took in the end, but my view has been that, at some point, whatever ambivalence he had and whatever other opportunities he had to do something else with the weapon that he had, for example, changed and that weapon became used for a different purpose.

Now whether that was, as you suggest, perhaps to confront his wife and sort of try to make one final attempt at remediation or not, I don't know but, in the end, that was ... you know, using that general rule that having the lowest number of suppositions that you have to put into place, that would be my sort of general view of it because the whole matter was set in the context of sort of a continually deteriorating situation between Mr. Desmond and his wife, and it's consistent with the literature that we've talked about earlier about the general

concept of homicide/suicide.

Q. Some other future-oriented moves that Cpl. Desmond had made was he had opened a bank ... the previous day, when he was here in Port Hawkesbury, I think he had opened a bank account at TD, I think because he was going to separate and needed his own bank account at that point, presumably. He had told his Uncle Kenny that he'd be there on the weekend. His uncle worked away for the week and he'd back on the weekend to help him build a shed. So some other curiosities there.

But coming back to the date and the sequence of events, Dr. Theriault, when Cpl. Desmond drove into the woods road, it seems like that would either be so that he could surprise Shanna or just conceal his presence there or better plan his arrival time. He may have been in the woods for half an hour or 40 minutes given the timeframe. Does that say anything to you? I guess you've spoken about the camouflage and being dressed up, dressed in camouflage being sort of a military theme.

A. Well, again, for me, as a forensic psychiatrist, that kind of action would suggest some sort of preparation. Now the question then becomes preparation for what? Was it preparation simply to go in and have a conversation with her, to confront his wife, or was it preparation to prepare for what ultimately

happened? I don't know, but it would just suggest some level of preparation, I would suggest, just by ... And I'm not a detective by any means, so that should be taken with a grain of salt, of course.

Q. There's some suggestion or some thought, Dr. Theriault, that because of the scope and the quality of the rifle, that perhaps he would be looking for a clean shot from a distance. Would that fit with what you've seen or what you've thought about the case otherwise?

A. You could write everything I know about firearms on one piece of paper, so I really don't have any comment about that.

Q. Okay, no, that's fine.

The next, I guess, fact I want to bring to your attention is the slashing of the tires. He had the knife with him, as you've seen in the picture. He slashed two tires on the same side. It seemed to be preventing the truck from being useable. And this was the same truck that he'd put off the road a couple of days before so, in a way, you may think, well, okay, it's animosity towards the truck itself as the source of a conflict but, given that it was ... you know, why not just scratch the paint or dent it or do something else rather than just slice the

tires, which really doesn't damage the truck itself. What does that tell you? I mean, in a way, that almost seems more consistent with somebody who is back in a war scenario. They're coming through the woods with their gun. They have their camo on, and slicing tires, and in they go.

A. Well, although ... I mean I can see that perspective. The other perspective, and I would just raise this as a hypothetical simply because, as a forensic psychiatrist, these are the things forensic psychiatrists think about is by slashing the tires, that would ... effectively may have prevented anybody from escaping the situation if they had the opportunity to do so. That would be another potential explanation for that sort of behaviour.

Q. There was another curiosity and, again, just a fact that was brought forward, which was that Cpl. Desmond carried the whole box of bullets with him and not just what was in the magazine. I'm not clear why he would've done that. I don't know if you have any thoughts on that, Dr. Theriault?

A. No. It's one of those ... as you've said, it's a number of sort of ... there are a number of these kind of peculiarities that really don't have any clear explanation as to why they occurred the way that they occurred, but it's left to

sort of various potential explanations for it, but I wouldn't have any sort of particular comment of why he had the box of ammunition the way that he did.

Q. And if we accept that there may have been dissociative episodes, or this entire incident was a dissociative episode, another potential entry point may have been after Shanna was shot, his wife, and then he realizes his mother and daughter are there too. If that was the sequence of events, which we don't quite know. So that seems like another potential manifestation of a dissociative episode. And then, potentially with a snapping to or, you know, a snapping back to reality, you know, in the course of that or during that, at which point he makes the ultimate decision on his own life.

So there seems like there may be, Doctor, if there was a dissociative episode, you know, three or four potential start points to that. Either potentially even back to, you know, the trauma of the divorce pronunciation; potentially at Leaves & Limbs; potentially talks to his therapist; or potentially during the scene in the home itself.

But the last thing I want to mention to you, I guess, Dr. Theriault, is some testimony given by Sgt. Rose-Berthiaume, because the police, of course, analyzed the scene very closely

and Sgt. Rose-Berthiaume noted that Cpl. Desmond had made the gun safe; in other words, he had taken the magazine out of the gun and there was only one bullet in there which he used on himself. And Sgt. Rose-Berthiaume hypothesized that, knowing weapons, Cpl. Desmond may have decided he was going to make the gun safe for whoever showed up, whoever discovered the scene, so that there would be no accidents or no incidents after that. And that seemed like the only reason to do that, to take the magazine out.

So, Doctor, I'm going to ask if that doesn't seem consistent with someone who snapped out of an episode, realized maybe the gravity of what they had just done, and then did this with the gun to make it safe, and then took his own life.

(16:50)

Anyway, you may not be able to make any of these determinations with a high level of certainty, Doctor, but I guess, given what we know and given some of these facts, do you see that as a potential possibility? And, I guess, would that strengthen your thoughts that we need to look into dissociative episodes even more?

A. Well, I think you're right with respect to the point that I don't think it could be ... any hypothesis in this

particular area could be held with any high degree of confidence simply because of the many variables that you've outlined.

Again, I'm struck, generally, as a forensic psychiatrist, by sort of following sort of the line of the information that I've got available to me. So I don't see a reason to think, for example, that a dissociative event, if it occurred, it occurred at an earlier time; for example, as early as when he was at the gun shop, because my expectation for somebody in a dissociative episode wouldn't be that they're organized in plan and plight and sort of what their general behaviour is, but more that they may be agitated and confused with respect to sort of what their surroundings are.

Even if I accepted that it was a dissociative event in its entirety, I would struggle with the idea that that would involve the person that it did, especially in the context of what we know about sort of their relationship and where it had come, and in light of what we know about homicide/suicide in general in individuals with problematic relationships.

That's not to say that ... I was struck by that last comment that you made because in my thinking about this, one of the things that I've struggled with a little bit is if we assume that Mr. Desmond killed his wife and then had decided that, as

part of that, he was going to kill himself, then we have the tragic circumstances of both his mother and his daughter being there, and we've had information that would suggest that his daughter wasn't actually supposed to be there, she was supposed to be, I think, off playing somewhere at that particular time.

Q. Yeah, there was an after-school program.

A. Yeah.

Q. And in addition, and you may not know this, Dr. Theriault, the television was found on in the back bedroom in the house at the time, and we don't know who was in that bedroom, if it was just his daughter, or just his mother, or both of them, or what.

A. And so you've got a number of different sort of scenarios, and I don't know that you can - or at least I can't anyway, come to sort of a strong opinion about which is the most likely. So they vary from, you know, in my view, that it was a homicide/suicide that, for whatever reason, then involved two other people, to one in which all four were planned. But I really struggle with that piece of it because I simply can't see that Mr. Desmond, particularly as it related to his daughter whom he did care about, even though he had somewhat of a, at times, distant relationship with her, that that would be part of

that. Although, as I've talked about, there are scenarios that have been considered where he could've, for example, thought of that as a, in a very sad kind of way, sort of a kind of deliverance from future pain for his daughter.

So, I mean, all of these are open options, of course, and the difficulty is is that in these kind of cases, you don't have the voice of the only person that actually ultimately knows what he meant to do at the time of the event.

Q. Well, that's right. Okay, thank you, Dr. Theriault. Those are the questions I wanted to put to you. Thank you for entertaining the questions. I know it wasn't detailed in your report that way, but those were things that I wanted to pass by you with your expertise, so thank you again.

A. Thank you.

THE COURT: Thank you, Mr. Rodgers. We are well past the time that we would normally adjourn for the day. I know that we have yet ... I know Mr. Hayne has some questions for Dr. Theriault as well. I think Dr. Theriault was able to make arrangements so he can return tomorrow morning.

So my question for ... Go ahead, Mr. Hayne. I know you've got something to say. What would you have to say?

MR. HAYNE: Yeah, I have no questions.

THE COURT: All right. I'm sorry, you have no questions?

MR. HAYNE: No questions.

THE COURT: Oh. I'm sorry.

MR. RUSSELL: And we would have one sort of minor point in re-direct, Your Honour, just to ...

THE COURT: All right. Well, you know what we'll do is we'll ... And unless anyone else has a short question as a follow-up, we'll hear from Mr. Russell and then we'll let Dr. Theriault go for today and tomorrow.

RE-DIRECT EXAMINATION

(16:56)

MR. RUSSELL: Thank you, Your Honour. I will be brief.

THE COURT: All right, thank you. Go ahead.

MR. RUSSELL: If we could bring up Dr. Theriault's report and, in particular, page 18. Dr. Theriault, my friend put to you various scenarios at great lengths, some of which was sort of, I would categorize, sort of speculating on what facts were, including Lionel Desmond waiting in the woods for a period of time, and there were a lot of questions put to you about this being a dissociative episode, that on January 3rd at some point,

Mr. Desmond may have been, due to his mental disorders, dissociated, in a dissociated state, and did his actions as a result of that dissociation.

I want to take you to paragraph 18 of your report which I think ... I'll leave it to you, but if you could read in what your opinion was, that starts with the paragraph ... Is this page ...

A. Page 18, yes.

Q. 18 of Dr. Theriault's report, sorry.

THE COURT: We have that, yes.

MR. RUSSELL: That looks to be 70 pages.

THE CLERK: Because that's all of the appendices as well. We are on page 18 which ...

MR. RUSSELL: Okay. If we could scroll down just a little bit. Keep scrolling down, please. Keep going down. I'm just looking for a page number off on the side. Okay. If we could look above, right at the top there, it says, "The extended time course ..." Dr. Theriault, if you could read that into the record, please?

A. I've noted:

> The extended time course of Mr. Desmond's actions on January 3, 2017, and his ability

to interact with others over that time, in my view, are not consistent with a dissociative episode and involving flashbacks.

Q. And if you could just explain to the Court for clarification, what do you mean when you say that and reach that conclusion?

A. Well, we've had some discussion about what may have been a flashback on the part of Mr. Desmond as it relates to the event occurring with his wife and how distressed he was about that, but we also have information that shows that on the date of January the 3rd, he had several conversations with several people over a period of time where he presented as organized, polite, controlled in his behaviour. And that included, of course, his going to the gun shop where, ultimately, he bought the weapon. So my expectation would be that for an individual in a dissociative state who's functioning as though they're acting in a war zone, that that level of calm demeanour would not really be present. I would be more of the view that they would present as agitated and distressed about sort of the things that are going on, not having a fairly fulsome conversation about what the best kind of ammunition would be for

you. And that goes back to my overall discussion about my sense of the picture as it developed of one where there's a great deal of ambivalence right up until the very end about which way this whole matter was going to swing because much ... some of the information would suggest a plan to carry out, at least in part, the actions that he ultimately did, and part of it would suggest that he had other things he was going to do with his time in the future and made future appointments and that. And so that sense of lack of certainty about which way things would swing is there right up through that timeframe. And, to my mind, that's more likely an explanation for the events that happened than a dissociative event.

(17:00)

Q. So, finally, Doctor, in terms of different scenarios of Lionel Desmond in a dissociative state and perhaps, as suggested to you, that he was re-enacting sort of experiences of war in flattening the tires, in your opinion, is there any suggestion that he was in a dissociative state when he committed these acts?

A. I can only really go based on the information that we've got available. So I don't have any information that would suggest, as we've just talked about, what I would expect to see

from somebody in a dissociative state, that would suggest that he was in a dissociative state through that period of time leading up to the event.

Q. Okay, thank you, Doctor.

EXAMINATION BY THE COURT

THE COURT: I want to ask a question about ambivalence. So when he's at Leaves & Limbs and he's purchasing the firearm, when he's making decisions about which firearm to purchase - because I think he may have looked at a couple and eventually settled on a used model - and then he looked at buying a case and they took the cases down and had them on the counter and I don't think the firearm fit in the case. And I think, eventually, they settled on wrapping it in a box with some tape. Then he made decisions about ammunition and he settled on some particular type of ammunition that would be non-corrosive and wouldn't have any kind of long-term, detrimental effect to the mechanism of the firearm or the barrel. If he had been settled on, in fact, he was going to obtain a firearm and go and just shoot his wife and commit suicide, maybe his choices would've been easier.

Now my question is, when you talk about ambivalence, does ambivalence enter into like a process of, well, I'll buy a firearm. If I'm going to do this, any firearm would do, but in any case I don't or change my mind, that's the one I would like to have around for some long-term other uses. When he buys ammunition, is that the kind ... like is he consciously aware of making those decisions or are those things that are running kind of in the back of his subconscious that, you know, maybe ...

A. I can't really ...

Q. ... that he sorts out or isn't even aware that he's making those decisions, in the context of ambivalence?

A. It's difficult to know for sure. I mean the best I can do is sort of provide an example. So for individuals that I've treated with suicidal ideation or suicide attempts, they will often say, Well, I've got something that I carry with me just in case, just in case I suddenly decide that it's time that I'm going to end my life, right? So it's that sort of ambivalence there about ... And, so, just by extrapolation, you could see that, for somebody like Mr. Desmond, whether that was there at a conscious level or whether that was something that was on his mind at that particular point in time, it's like, you know ... and, again, you have to understand that this is

speculative, in a way, because we don't have Mr. Desmond.

You know, on the one hand, it's like, Okay, I've got my firearms certificate; I can have a weapon, and this is ... you know, I can use it for all sorts of things, but I could also use it for this. And that's on his mind because, of course, it's in the aftermath of the whole conversations that he's had with his wife over the previous three days about the potential dissolution of the marriage.

So in that sense ... And we know, from studies on suicide, that 50 percent of them are impulsive; they're just sort of "in the moment" things, but if you're going to have an impulsive suicide, it's best not to have the person have the means to accomplish it and so, by extension, that would be true in this situation as well.

Q. All right, thank you.

Dr. Theriault was retained to provide the Inquiry with the report that he eventually produced, and part of that report also contains his *CV*, and he's testified today as a forensic psychiatrist, and certainly in an expert capacity, and although I didn't make a particular ruling on that, I just want to make it clear on the record that I made arrangements to retain the doctor in his capacity and, because of his expertise, I accept

that he is an expert in that area and his evidence is accepted in that regard, as is his report. It will be read as an expert report as well on the Inquiry, just to make that clear.

Dr. Theriault, we, in this room, collectively, have dealt with the circumstances relating to the events of January 3rd and the life and times of Cpl. Desmond and his family, and many questions arise from my point of view, and I'm sure from Counsels' point of view, as to the circumstances in trying to make sense in the way that I think about things, and I don't always have the benefit of the expert analysis that you can bring to the Inquiry, and that's why your evidence is here, and to help shed light on the Inquiry's understanding of the circumstances and help, as well, give us some insight as to what recommendations might be useful on a "go forward" basis to make the various systems at play better to be able to intervene in a timely basis, when that's possible, to prevent such tragedies. And so, in that regard, your time here today and the evidence you've given, and certainly your report that you prepared, has been beyond helpful in that regard. So, thank you, sir, for your time. Very much appreciated.

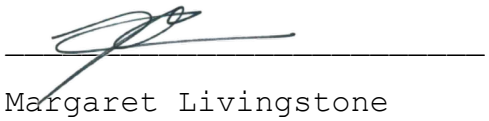
A. Well, thank you, Your Honour. I'm glad I could be of assistance to the Inquiry.

Q. Thank you. Counsel, we'll adjourn for the day. We'll be back tomorrow morning at 9:30 with Dr. Jaffe. All right, thank you.

COURT CLOSED (17:08 HRS.)

CERTIFICATE OF COURT TRANSCRIBER

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



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