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 3, 2021

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1 **NOVEMBER 3, 2021**

2 **COURT OPENED (09:31 hrs.)**

3

4 **THE COURT:** Good morning.

5 **COUNSEL:** Good morning, Your Honour.

6 **THE COURT:** Good morning, Dr. Jaffe.

7 **DR. JAFFE:** Good morning, Your Honour.

8 **THE COURT:** Perhaps before we begin, we could have Dr.

9 Jaffe sworn, please.

10

11 **DR. PETER JAFFE, affirmed, testified:**

12

13 **THE COURT:** Mr. Murray?

14 **MR. MURRAY:** Thank you, Your Honour.

15

16 **DIRECT EXAMINATION**

17

18 **MR. MURRAY:** Good morning, Dr. Jaffe. How are you this

19 morning?

20 **A.** So far so good. We had our first snowfall, so it's a

21 bit discouraging to see all the snow on the ground.

22 **THE COURT:** That's sad for you.

DR. PETER JAFFE, Direct Examination

1 **MR. MURRAY:** We're still double digits in the temperature
2 here. Dr. Jaffe, as we go along, of course, we have had
3 generally good luck with the technology but, every now and
4 again, people will freeze up. If at any point along the way
5 you're unable to hear me or see me, or vice versa, we'll let the
6 other know and we'll get the problem corrected. Okay?
7 **A.** Thank you.
8 **Q.** All right, very good. So to begin, Dr. Jaffe, perhaps
9 to begin you could tell the Inquiry your name, please?
10 **A.** Peter Jaffe, J-A-F-F-E.
11 **Q.** For the record, Dr. Jaffe, you were retained by the
12 Inquiry, were you, to help us with and to give us an opinion in
13 the areas of domestic violence, domestic homicide, domestic risk
14 assessments, and domestic violence prevention. Would those be
15 fair characterizations of what we've asked you?
16 **A.** Yes.
17 **Q.** Thank you. And you've had an opportunity to review
18 many of, perhaps not all, but many of the materials that we've
19 gathered during the course of the Inquiry and in formulating
20 your opinion?
21 **A.** Yes, I have.
22 **Q.** Thank you. Dr. Jaffe, I think the most appropriate

1 way for us to begin is to have a discussion of your
2 qualifications and the work that you've done over many years.
3 So perhaps we can bring up your *curriculum vitae*, which I
4 believe is marked as Exhibit 324. I don't know that your
5 *curriculum vitae* has a date on it but this is one that you
6 provided us. This is an up to date version of your *CV*, is it,
7 as best you can tell?
8 **EXHIBIT P-000324 - *CURRICULUM VITAE* - DR. PETER JAFFE /**
9 **EXHIBIT P-000334 - REPORT - DR. PETER JAFFE - OCTOBER 22, 2021**
10 **A.** It's up to date, yes, up to date as to the end of
11 September.
12 **Q.** Okay, very good, thank you. So, Dr. Jaffe, you're
13 currently a professor in the Faculty of Education at University
14 of Western Ontario and you are the Academic Director for the
15 Centre for Research and ... Is it Research and Education on
16 Violence Against Women and Children?
17 **A.** Yes. Centre for Research and Education on Violence
18 Against Women and Children. I should just clarify one thing I
19 just noticed. So, in the past several months, I've become
20 Professor Emeritus. So I'm retired and just continuing research
21 and clinical work but without taking on any graduate students or
22 having any budget responsibilities.

DR. PETER JAFFE, **Direct Examination**

1 **Q.** So I take it congratulations are in order for that,
2 are they?
3 **A.** Yes, I'm down to 40 hours a week.
4 **Q.** Good. Dr. Jaffe, your training, obviously, as we can
5 see from your *CV*, is in the area of psychology and starting, I
6 guess, in 1971, you received your MA from Western in Clinical
7 Psychology and your PhD, you received in 1974 from Western in
8 Clinical Psychology. And you've worked and researched and
9 taught in the area of psychology since that time at Western,
10 have you?
11 **A.** Yes. Just to clarify, so early in my career, I taught
12 at Western and then I took a full-time job in the community as
13 Director of the London Family Court Clinic and I continued with
14 some teaching at the university but more as an adjunct faculty
15 member, just teaching from time to time in selected courses or
16 guest lectures. And then back in 2005, I went full time to
17 Western where I continued as a full-time professor but keeping
18 up a clinical practice through the London Family Court Clinic.
19 **Q.** Okay, and I wanted to ask you about that. And just I
20 see on the first page of your *CV*, you have been a Registered
21 Psychologist since 1974 and continue to be to this day.
22 **A.** That's correct.

1 **Q.** All right. So, yes, I see that in various capacities
2 you've worked as a professor in various departments, psychology,
3 psychiatry and education, teaching but I see that you had other
4 employment over the years. So perhaps I can ask you about that.
5 First of all, from 1973 to 1975, your *CV* indicates you were
6 the Director of the Family Consultant Service for the London
7 Police Service, is that correct?
8 **A.** Yes, so that was, our police chief noted that domestic
9 violence calls were second only to motor vehicle accidents as
10 the most common request for police service and he developed a
11 family consultant program which, basically, we were five mental
12 health professionals. We worked on shifts around the clock
13 helping police respond to domestic violence calls. We had an
14 unmarked police car, police radio. The officers went to the
15 calls first and then we were called in then to counsel the
16 victims or perpetrators or children living with the violence.
17 So that was a very innovative program back in the mid '70s.
18 **Q.** It would have been, I would think, for the early to
19 mid '70s. Was it then that you developed an interest in dealing
20 with issues of family violence or domestic violence?
21 **A.** Yes, it was an overwhelming job. If you can imagine,
22 I was a young psychologist. I would be getting calls, I would

1 be working through the night getting calls from all parts of the
2 city and trying to make sense of domestic violence and the
3 aftermath of domestic violence. And it was an area that was so
4 complex and there weren't a lot of people at that time doing
5 research in the area and I certainly got totally engaged in
6 trying to understand some of the questions in those days. You
7 know, the common, just for an example, we would get calls and we
8 have women who are terribly abused and then a month later we
9 would be called again and she was back with him. So, in those
10 days, the issue was more of how could you get help for people.
11 You know, why did women keep going back to abusive
12 relationships, why didn't they leave and stay out of the
13 relationship?
14 So there were many issues including the big issue at that
15 time was the impact of domestic violence on children. You know,
16 were we doing enough to help the children who were exposed to
17 this violence, what kind of supports were needed. And that
18 became, just as a side, that became one of my major issues in my
19 research because our police chief used to point out that the
20 families that we were intervening with, he had intervened with
21 their parents and their grandparents. So he was often talking
22 about the intergenerational transmission of violence and what

1 children had learned growing up with the violence.
2 So those are just some examples of things that we were
3 dealing with back in the mid '70s.
4 **(09:40)**
5 **Q.** And you said the body of research at that time was
6 more limited on the topic?
7 **A.** It was very limited. You could probably, if you went
8 to the library, and sometime between 1975 and 1980, and you
9 said, you know, give me all your books and articles you have on
10 domestic violence, it would be in a very small box, you know.
11 Today, go to the internet and you look up the term
12 "domestic violence" and you find millions of references, you
13 know. References on treatment of men, treatment of victims of
14 domestic violence, research on children living with domestic
15 violence. So the work has certainly exploded certainly over the
16 last three or four decades.
17 **Q.** And you began to do some research in the area yourself
18 as a psychologist and an academic at that time, did you?
19 **A.** Yes, a lot of my initial research was looking at the
20 police response to the domestic violence. We began to study,
21 you know, the costs and benefits of police laying charges in
22 cases of domestic violence, when they had reasonable and

1 probable grounds that an assault had taken place.

2 Because back in those days, domestic violence was not seen
3 as criminal conduct. Domestic violence was seen as a private
4 family matter. And without reviewing the whole history, if you
5 go back to the late '70s or early '80s in London, charges would
6 have been laid in three percent of all domestic violence cases.
7 Most women were told that if they wanted to file charges, they
8 should go down to see a Justice of the Peace and swear a private
9 information. But domestic violence wasn't really a public
10 policy issue and only exceptional cases made it through to the
11 court.

12 **Q.** You said that subsequently in 1975 you took a job as
13 the Executive Director for the London Family Court Clinic.

14 **A.** Yes.

15 **Q.** Tell us about that. What was the London Family Court
16 Clinic and what was your role as Executive Director?

17 **A.** The London Family Court Clinic began as a children's
18 mental health center dedicated to issues that bring children and
19 families into the justice system. So we would be getting
20 referrals, mainly from the Family Court, related to issues, in
21 those days, around delinquency, now young offenders getting
22 referrals for assessments about helping the judges understand

1 why someone was in trouble with the law and what kind of
2 remedies may be required to address those issues.
3 We also were involved in child custody and access disputes
4 where parents were separating and there was an argument about
5 the appropriate parenting plan after separation. So we would be
6 appointed by lawyers jointly or ordered by the court to do a
7 child custody evaluation.
8 We would also be involved in child protection hearings
9 where there would be an issue as to whether the parents were fit
10 to have ongoing care and control of their children. That often
11 is a dispute between the Children's Aid Society and the parents
12 as to the best plan moving forward.
13 And more recently, the referrals we were getting related to
14 civil action. So we would be dealing with often individuals who
15 were sexually abused in childhood, you know, by a priest, a
16 teacher, or coach and we were doing assessments looking at the
17 long-term impact of the abuse they had suffered.
18 And we also were involved, I'd say in the last 10 years, in
19 the area of class action lawsuits where there was a group of
20 claimants, obviously filing a class action. They were,
21 obviously, representative plaintiffs and we would be involved in
22 helping determine from our research review what the common harm

1 may be in those cases as part of the court's determination to
2 certify the class action.
3 So that's a range of the cases we would be involved in.
4 **Q.** Right, okay. And you did that work for 25 years,
5 basically, 26 years.
6 **A.** Yes, and continuing now. So I still, I'm Director
7 Emeritus and Senior Consultant to continue. So, you know, to
8 this day, I would still have seven or eight active cases in all
9 those areas, both in criminal context in terms of questions
10 either from the Crown or Defence.
11 For example, a woman who may be accused of killing her
12 partner and the issue would be whether it was self-defence or
13 not. So I would be called in for assessments in that area.
14 Ongoing child custody disputes, usually with domestic violence
15 as a factor. And ongoing issues of historical abuse. So I'm
16 still continuing in that work.
17 **Q.** And so you would be called up to do assessments as a
18 psychologist in any of those areas?
19 **A.** Yes.
20 **Q.** I see over the years as well, you've taught,
21 obviously, in the Department of Psychology, also in the
22 Department of Psychiatry, so to medical students, do I

1 understand that as well?

2 **A.** Yes, so certainly a lot of the work would have been

3 working with forensic psychologists and psychiatrists and also

4 more broadly, for example, talking to students in family

5 medicine or other areas about the impact of domestic violence on

6 victims and perpetrators and warning signs and looking at what

7 doctors could do to screen these cases appropriately.

8 **Q.** As we go on, and I think ultimately you may speak

9 about recommendations in this area as well, but for students of

10 medicine, you said that you've had an opportunity to speak to

11 some of them about risk factors for domestic violence and

12 warning signs. Over the years, have you noticed whether that

13 has increased, the education in professional programs, like

14 medicine, in the area of domestic violence?

15 **A.** Certainly there's been slow and steady improvement.

16 There's certainly much more awareness. I, sort of to summarize

17 where I think we're at, I feel in a sense we're 40 kilometers

18 down a 100 kilometer road. You know, we're no longer living in

19 the Dark Ages where people can't believe this happens and they

20 see it as a private family business that, you know, we shouldn't

21 be involved or it's not part of medicine or not part of

22 psychology or psychiatry. So I think we've come a long way but

1 there's still a lot of work to do.
2 I think the new generation of lawyers and doctors and
3 psychologists are much more aware. There's, you know,
4 increasing demands in terms of standards of practice in many
5 sectors but we still have a ways to go.
6 **Q.** Right. Okay. And I see you're also a consultant and
7 faculty member for the National Council of Juvenile and Family
8 Court Judges, Futures Without Violence. What is that program or
9 what is that entity?
10 **A.** For the last 20 years, I've been involved in
11 developing a program, this is for American judges, through those
12 two organizations. So these are judges both in the Criminal and
13 Family Court context. We developed a four-day training looking
14 at the dynamics in domestic violence cases, looking at cultural
15 issues in terms of understanding cultural context. In these
16 cases, looking at fact-finding recent court decisions.
17 So it's a four-day program. I would be one of 10 faculty
18 members for this national program. We would have judges from
19 all over the US. So I would be delivering part of the program,
20 certainly dealing with the dynamics of domestic violence issues
21 and the impact on children and some of the major issues around
22 perpetrator's behaviour and victim's reluctance to come forward.

1 So it's a four-day intensive program. When we started, it
2 was delivered four times a year. Judges would come from all
3 over the US. Obviously, it stopped during COVID and now we're
4 at this point just doing on-line webinars for judges on a more
5 limited basis and then, hopefully, starting up again in the
6 spring of 2022.
7 **(09:50)**
8 **Q.** And you say that's for judges in the US, is it?
9 **A.** Yes.
10 **Q.** All right. And then finally and since, well, I guess,
11 2005, you have been a professor in the Education Department and,
12 as you say, now Academic Director at the Centre for Research and
13 Education on Violence Against Women and Children. Perhaps you
14 can give us a sense of what the Centre for Research and
15 Education on Violence Against Women and Children is?
16 **A.** It's really to what its name is. It's a center that's
17 been there for over a quarter century. It's dedicated to
18 promoting applied research on the issues of violence against
19 women and children. So we would be involved with community
20 partners, either locally, provincially, or nationally,
21 researching critical issues.
22 So, for example, we're just completing a six-year grant

1 from the federal government, social science humanities research
2 grant looking at domestic homicides across Canada. So that
3 would be a grant that I would be partnering with a professor at
4 the University of Guelph, a criminologist named Myrna Dawson,
5 and the two of us would be working with 12 other universities
6 across Canada, as well as 50 community partners from police,
7 coroners, mental health professionals, social service
8 professionals, working on trying to identify the patterns of
9 domestic homicide across the country, as well as looking at the
10 response of different service sectors, law enforcement, health,
11 corrections. And then also part of that research, we would be
12 interviewing surviving family members who lost someone to
13 domestic homicide or victims who survived severe domestic
14 violence to understand the responses they received and
15 understand some of the risk factors and missed opportunities to
16 intervene in these cases.
17 **Q.** How long is it you said the Centre has been in
18 existence?
19 **A.** The Centre has been around for 27 or 28 years. It
20 began, actually, just for context, after the events of December
21 6th at L'Ecole Polytechnique in Montreal with the massacre of
22 young engineering students. The federal government made a

1 commitment to increase research on the issue of violence against
2 women and children and they funded five research centers across
3 the country. So there was one in New Brunswick, University of
4 New Brunswick; one in Quebec, the University of Laval; one in
5 London at Western; one in Manitoba, the University of Manitoba;
6 and one in BC at Simon Fraser University. So the federal
7 government funded five research centers. So we're one of five
8 centers of excellence trying to do research on the issue of
9 violence against women and children and making sure that the
10 research not only is completed but also disseminated in a way
11 that's practical for frontline practitioners across different
12 sectors.
13 **Q.** And have you been affiliated with the Centre since
14 it's beginning or since 2005?
15 **A.** Yes, I was there when the Centre was first funded.
16 That would be, I guess, 27 or 28 years ago. So I was there at
17 the outset in terms of one of the founding fathers of the
18 Centre. We had, it was a partnership with Western, Fanshaw
19 College, and also our local coordinating committee dealing with
20 issues of domestic violence. So I was there at the outset. So
21 I was on the Board of Directors and then left the Board and then
22 was eventually hired as a professor and then asked to run the

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1 Centre as the Academic Director.

2 **Q.** And the Centre is affiliated with the Faculty of

3 Education at Western, is it?

4 **A.** Yes.

5 **EXHIBIT P-000338 - ANNUAL REPORT 2020-2021 - WESTERN CENTRE FOR**

6 **RESEARCH AND EDUCATION ON VIOLENCE AGAINST WOMEN AND CHILDREN -**

7 **LEARNING TO END ABUSE**

8 **Q.** I actually had one of, I think perhaps the most recent

9 Annual Report for the Centre marked as an exhibit, I think it's

10 338, if we could bring that up. I would assume that over the

11 years there have been a number of research priorities and

12 research projects that the Centre has undertaken in its

13 existence. I'm looking perhaps at page 22 of the Annual Report.

14 Are these some of the current research grants, projects and

15 contracts that the Centre is working on at the present time or

16 has been working?

17 **A.** Yes.

18 **Q.** And the particular project that you mentioned that

19 you're working on with Myrna Dawson, what is that again?

20 **A.** It's at the top left-hand corner of those boxes. So

21 it's the CDHPI, scroll to the top of that page.

22 **Q.** Canadian Domestic Homicide Prevention Initiative?

DR. PETER JAFFE, Direct Examination

1 **A.** Yes.
2 **Q.** And it's a little further up, I think, the other way.
3 There we are. And we have some other materials marked on the
4 Canadian Domestic Homicide Prevention Initiative. The current
5 program is the Canadian Domestic Homicide Prevention Initiative
6 with Vulnerable Populations.
7 **A.** Yes, so we developed a database looking at all
8 domestic homicides but our research focused on four vulnerable
9 populations - Indigenous women, immigrant refugee women, women
10 living in rural remote northern communities, and also children
11 living with domestic violence.
12 **EXHIBIT P-000343 - CANADIAN DOMESTIC HOMICIDE PREVENTION**
13 **INITIATIVE**
14 **Q.** Oh, I think we have it marked there, I'm not sure
15 which exhibit it is, 343, perhaps. Those particular initiatives
16 or those particular vulnerable populations, why were those
17 chosen?
18 **A.** Those appear to be populations that accounted for the
19 majority of domestic homicides and we were limited. Obviously,
20 research grants need to have some focus and scope. Obviously,
21 there are other vulnerable populations. You know, there's
22 certainly, you know, women with disabilities, older women

1 dealing with physical and mental health difficulties who are
2 more vulnerable because of that situation. So there are
3 multiple vulnerable populations but our research focused on four
4 major groups.
5 **Q.** That research, that particular project is still
6 ongoing, is it?
7 **A.** It's going to wrap up as of end of December this year
8 and, actually, we're just ... I have a meeting on Friday just to
9 review the final report to the funder, so it will be wrapping
10 up. I mean the work will continue because we have a
11 database with 800, unfortunately too many cases, 850 domestic
12 homicide victims between 2010 and 2019 in Canada. So we have
13 data gathered from court decisions, media reports, and we have
14 been working with coroners and medical examiners across the
15 country. So we have a database.
16 We also have interviews with over 350 professionals from
17 different sectors dealing with issues of risk assessment, risk
18 management. And we also have hundreds of interviews with
19 survivors or victims of domestic violence.
20 So that data will continue and, in the years ahead, there
21 will be other professors, either in my university or in other
22 universities who are working with graduate students looking at

1 analyzing that data, looking at different questions.
2 **(10:00)**
3 **Q.** So the purpose of the project as much as anything was
4 to gather that data and make it available in one place for
5 academics and others to consider and work with in the future?
6 **A.** Yes, and also disseminate the information. So through
7 that research project we have a number of learning briefs and
8 multiple publications, and those publications would deal with
9 things such as police response, the response of child protection
10 to children living with domestic violence, the vulnerability of
11 particular populations.
12 We published a book, I co-authored a book with two other
13 authors, called **Preventing Domestic Homicides: Lessons Learned**
14 **from Tragedies** where we captured some of this research. So
15 again, there's multiple publications and we share them on a
16 daily basis.
17 Just one thing, it might be an obvious point but I'll make
18 it. In the old days when I was starting off as an academic, you
19 know, you published studies in an academic peer-reviewed journal
20 or you'd write a book and you hope people would read it
21 eventually.
22 Today it's quite different in the sense that the big issue

1 is knowledge mobilization. So we try to take our work and put
2 it into learning briefs, share it across different sectors in
3 ways that are much more digestible. So a lot of people would
4 have trouble digesting academic publications so we've tried to
5 translate the work and share it with different organizations so
6 it gets into the hands of practitioners a lot quicker.
7 **Q.** Okay. Which obviously is something that would be of
8 interest to you or of concern to you that it actually gets into
9 the hands of the people that need it and can use it?
10 **A.** Yes, that's a top priority. And actually what's
11 interesting is with government grants now more and more it's ...
12 you know, they don't want just a count of the number of academic
13 publications you have, they want to make sure it's available on
14 a public website; they want to know how many people went to the
15 website, how many people downloaded it. So what's really
16 important to most funders is that the information is readily
17 accessible and being used on a regular basis.
18 **Q.** And I think the document that we have up actually
19 refers to the Canadian Domestic Homicide Prevention Initiative
20 as a "knowledge hub", which is perhaps a good way of describing
21 the way that the information is gathered and contained and
22 available.

1 I see the document that we have pulled up also says that
2 the Canadian Domestic Homicide Prevention Initiative has done
3 work or has been involved in the creation of the Domestic
4 Violence Death Review Committees across the country or has
5 contributed to that in some way. Do I understand that
6 correctly?
7 **A.** Contributed is probably a good word. So there's a
8 number of Canadian Domestic Violence Death Review Committees
9 across different provinces so certainly we work with committees,
10 we share information, but certainly each committee, you know,
11 has arisen from a provincial government's commitment to start a
12 committee. And obviously we've been available on a needs basis
13 as consultants or providing supporting documents.
14 **Q.** Just going back to the annual report from the Centre,
15 the research grants, projects and contracts, another that I
16 wanted to ask you about because obviously on your *CV* it's a
17 significant area of research for you was the Neighbours, Friends
18 and Families Program. Can you tell us a little bit about that
19 program and what the work is there you've been doing?
20 **A.** The Neighbours, Friends and Family program is really a
21 public education campaign designed to increase the awareness of,
22 you know, friends, family, neighbours and even co-workers on the

1 issue of domestic violence and potentially domestic homicide.
2 Making sure that the community is much more informed in terms of
3 how to potentially talk to victims or perpetrators of domestic
4 violence to make sure they get help on a timely basis.
5 That research grant began because one of the number one
6 recommendations that were coming out of the Ontario Domestic
7 Violence Death Review Committee was the lack of public
8 information about how dangerous domestic violence was and how
9 predictable and preventable it was.
10 So that grant really developed from the initial work of the
11 Ontario Domestic Violence Death Review Committee where often we
12 would be talking to friends or family members or co-workers who
13 saw the warning signs but, you know, didn't know what to say,
14 didn't know what to do, wished they had reached out earlier.
15 And sometimes, you know, there are many things that impeded
16 them. They're worried about putting their nose in somebody
17 else's private business or they were worried it was going to
18 make it worse to talk about it. And so that campaign really is
19 trying to address some of those basic issues.
20 I should also say that that campaign is through our
21 research center but there are sister campaigns. There's one
22 directed to Indigenous people in Ontario. There's also one

1 directed to immigrant refugee population and it has information
2 in, I think, 14 or 16 different languages. And there's also a
3 francophone campaign dealing, you know, dealing with
4 francophones in Ontario. So there's four sister organizations
5 all with the same mandate.
6 **Q.** So I guess the need for public education for, as the
7 name suggests, neighbours, friends and families who may not know
8 what to do if they have a sense that there is violence in a
9 family setting or domestic violence, that's a problem, I guess,
10 that you've identified and have been working on. Do you see
11 some success or some change in that area, in the public
12 education campaign?
13 **A.** Yes. Again, it would be similar in all areas, there's
14 definitely a shift, there's definitely much more public
15 awareness. There's also ... we see victims who are reaching out
16 for help earlier so certainly, you know, there's progress but,
17 again, we've a long way to go before we've achieved, you know,
18 total penetration in terms of the public's mind. So there's
19 still a lot of ... there's obviously a lot of resistance and
20 some of it I've addressed in my report. There's a lot of issues
21 that stop people from really talking about the issues more
22 openly, more directly, and having the skills to talk to friends

1 or ... to talk to victims and perpetrators.
2 So actually some of our work, we've done workshops.
3 Workshops with community groups. We've actually done workshops
4 in the schools. Because on the continuum of domestic violence
5 there's also dating violence that exists in high schools and
6 colleges and universities, certainly younger populations are
7 vulnerable.
8 So we actually, in some of our workshops, we share
9 information but we also role play, you know, about what you
10 might say to a friend or family member in that situation. So
11 knowledge is certainly step one in awareness, but you also have
12 to go beyond knowledge to think about what would you say and do
13 in that circumstance.
14 **Q.** Right. Okay. And just as we were looking at the
15 research projects that the Centre has undertaken, one that has
16 been of interest to us because we've heard evidence locally
17 about it is research on the Nova Scotia Men's Helpline. I
18 believe that research was conducted by your colleague Dr. Scott,
19 is that correct?
20 **A.** Yes.
21 **Q.** Are you familiar with that at all or was that more her
22 work?

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1 **A.** It's more her work. I can just tell you briefly that
2 one of the priorities in all the work Dr. Scott does is trying
3 to engage men on this issue and making sure men reach out for
4 help before it's too late. So certainly her work around the
5 help line and other work she does is trying to prevent the
6 escalation of domestic violence by getting men who are involved
7 in this behaviour to get help early and get them into
8 appropriate programs.
9 **(10:10)**
10 **Q.** Right. Thank you.
11 **A.** I can just mention two things. It's really more her
12 area but to me it's a reflection on the work that's being done.
13 She worked on a couple of research grants. One is looking
14 at the benefit of reaching out to men early, right after they've
15 been charged with domestic violence rather than waiting for the
16 criminal justice system which often proceeds very slowly. So
17 she's developed a program with outreach to men after they've
18 been charged.
19 So to avoid, for example, you know, men who have been
20 charged feeling more depressed and desperate, you know, drinking
21 too much, ruminating on ways to get even, they developed an
22 outreach program that works independently of the criminal court

1 in the sense that they were told this is not going to get them
2 off their charge, this is not going to get a lighter sentence,
3 but this is to make sure that things don't go from bad to worse
4 while they're waiting, you know, for the criminal justice system
5 to do its work. And in that research she's reduced new
6 incidents of violence in half by doing an outreach and providing
7 support for men and support may be helping with issues around
8 housing and employment, with getting immediate counselling. So
9 that work has been very effective.
10 She's also developed a parenting program for men involved
11 in domestic violence. When we think about domestic violence we
12 usually think about it as an adult issue that involves intimate
13 partners and her work is trying to help men and look at their
14 role not only as an intimate partner but also the impact they're
15 having on their children who are being exposed to this violence.
16 So she developed a program called the Caring Dads program, which
17 sometimes is court-ordered and sometimes men attend on a
18 voluntary basis to reflect on the role domestic violence has on
19 men as parents, in terms of the kind of role models they are and
20 try to motivate them to change based on the impact of their
21 behaviour on their children.
22 And for many men they often reflect on their own childhood

1 and things that they were exposed to, and this may be a major
2 motivator in terms of getting them to change. So I wanted to
3 mention those two programs that are part of her area of research
4 and part of her specialization.
5 **Q.** And the first program you mentioned, the outreach
6 program, do you recall the name of that offhand?
7 **A.** It was an early intervention program. I could follow
8 up with sending a publication. She published her study and it's
9 quite an amazing study and it's getting us to re-think the work
10 we do locally. And, again, it hasn't been picked up on a
11 national basis but certainly it's been picked up locally in a
12 number of other communities to try to make sure, you know, men
13 get help and don't become more desperate while they're waiting
14 for the criminal justice system to do the things that they do in
15 normal course.
16 **Q.** Right. Thank you. Yeah, if you could that would be
17 helpful.
18 Dr. Jaffe, I guess I've cycled away from your *CV* a bit but
19 I'd like to come back to it. I'm just touching on some of the
20 other work you've done and I think it would certainly be
21 appropriate to mention your *CV* contains a number of academic
22 honours and awards, they are numerous, but not the least of

1 which is you are a recipient or an Officer of the Order of
2 Canada since 2009?
3 **A.** Yes.
4 **Q.** It's important to mention that.
5 **A.** Actually, just as an aside. I have four sons and one
6 of my sons went to school and the month after I was named an
7 Officer of the Order of Canada he told his teacher that I was an
8 Officer of the Order of Canada and his teacher said that's not
9 very likely; usually those are ... that's more an award for
10 someone like Wayne Gretzky or Celine Dion and he said no. He
11 told his teacher, no, that's true. And the teacher said, I'm
12 sure you love your dad very much but I'm not sure that's
13 possible. And they had a SmartBoard in the classroom and they
14 did an internet search and found it. The teacher said, I'm
15 sorry, Aaron, I'm looking forward to meeting your dad at parent-
16 teacher day and that was ... anyway, that's ... yes, that was a
17 very special honour.
18 **Q.** Right. Well, I think, to my knowledge, you're the
19 first witness we've had at the Inquiry who's a Member of the
20 Order of Canada, so it's rarified company. Congratulations.
21 Dr. Jaffe, your *CV* contains also information about
22 different venues where you've given evidence before and I see

1 that you have consulted and/or given testimony in a number of
2 either inquests, coroner's inquests, or inquiries not dissimilar
3 perhaps to the one that we're conducting here and I wanted to
4 ask you about a couple of those, we don't have to go into great
5 detail obviously because some of the subject matter is not
6 always pleasant. But I know recently or at least in 2015 you
7 testified at a PEI inquest into child homicide/parental suicide.
8 Is that correct?
9 **A.** Yes.
10 **Q.** That was the Nash Campbell and Patricia Hennessey, do
11 I have the names correct in that matter?
12 **A.** Yes.
13 **Q.** Okay. And that Inquiry touched on the concept,
14 correct me if my terminology is not correct, in filicide? Is
15 that the term for the killing of a child?
16 **A.** Yes.
17 **Q.** Did you examine in that ... I had a chance to look at
18 some of the material from that, risk factors and warning signs
19 for child homicide?
20 **A.** Yes, that was a major theme about all the ... it was a
21 situation that involved a parent, a mother with extensive mental
22 health history around depression and prior suicide attempts. It

1 also involved ongoing child custody disputes with multiple court
2 hearings and also a history of domestic violence. So it had
3 multiple issues and obviously multiple risk factors that were
4 present before the homicide/suicide.
5 **Q.** All right. And others that are listed here, the May-
6 Iles Inquest from 1998 and the Hadley Inquest from 2002, both of
7 those were inquests into incidents of domestic homicide, is that
8 correct?
9 **A.** Yes, they were homicide-suicides. And actually, just
10 a note on those. With the Ontario inquests there's an inquest
11 jury and in both those inquests there was a recommendation from
12 the jury that every domestic homicide should be reviewed in the
13 Province of Ontario and those inquests led to the development of
14 the Domestic Violence Death Review Committee, so that was a jury
15 recommendation.
16 **Q.** I had seen that and that's why, in fact, I was asking
17 about both of those. Those were recommendations from both of
18 those juries in both of those inquests, that there be some form
19 of review of domestic homicides?
20 **A.** Yes, that's the same. Obviously inquests and fatality
21 inquiries in this situation obviously are time-consuming and
22 expensive endeavours, important endeavours, and the jury in

1 these cases said, you know, that every death deserved a review.
2 Obviously an inquest isn't possible in every case or an inquiry
3 but they thought that every case should be reviewed by a multi-
4 disciplinary committee to understand the warning signs and the
5 potential missed opportunities and what we can do to prevent
6 deaths in similar circumstances in the future.
7 **Q.** And those, in part, led to the creation of the ... I
8 take it Ontario was the first Domestic Violence Death Review
9 Committee in the country of the provinces?
10 **A.** Yes. So the Ontario committee ... the initial work
11 began to develop it in 2002 and the first cases were reviewed in
12 2003.
13 **Q.** Okay. And the Ontario committee obviously has been
14 ongoing since then and now we have similar death review
15 committees in a number of the provinces. Most recently I think
16 us or we're on the road to it here in Nova Scotia.
17 **A.** Yes.
18 **Q.** One other of the inquests that I wanted to just ask
19 you about briefly was the Dupont Inquest. I understand there
20 were ... we had talked about this because there was at least one
21 similarity to our situation with that particular situation, was
22 there?

1 **(10:20)**
2 **A.** Yes, the Dupont Inquest involved a murder-suicide. It
3 was an anaesthetist who killed a nurse. They worked in the same
4 hospital together. They had been in an intimate relationship.
5 She broke up the relationship but he continued to stalk, harass
6 and threaten her, including in the workplace, and there were
7 multiple warning signs. There were many risk factors, many
8 missed opportunities. The violence was seen by others in the
9 workplace. And one of the major recommendations that came from
10 that inquest was changing our health and safety legislation to
11 include domestic violence as a workplace issue.
12 So if the employer knows or ought to know that an employee
13 is a victim of domestic violence and there's any risk present to
14 them or to the workplace they, the employer, has an obligation
15 to provide safety and support for that victim.
16 So that inquest changed the landscape in terms of the
17 employer's responsibility and the workplace responsibility to
18 address these issues rather than look the other way.
19 And I would say that that's an example of a recommendation
20 that was very radical and has a lot of uptake because it's
21 actually legislation. So every employer has to address this
22 issue. This is just a concrete example, that even the Toronto

1 Blue Jays baseball team every single baseball player, every
2 single member of the organization had to attend training on
3 domestic violence and also on sexual assault to be aware both of
4 the nature of the issue, the things that they could do or say to
5 try to support somebody or report things up to senior
6 administration. So it's every organization from small
7 organizations to big organizations followed through on those
8 requirements.
9 **Q.** I think when we had spoken about this first, one of
10 the issues that we've touched on here and we'll obviously get to
11 the specifics of the Desmond case, but was that Shanna was
12 training as a nurse, as the victim in the Dupont Inquest was.
13 And the question of whether when a victim of domestic violence
14 may be a professional themselves or may have training, that
15 others may assume that they are not in danger or that they are
16 better able to protect themselves and that's not always the case
17 I take it, obviously?
18 **A.** No, not at all. In fact, some of the cases we
19 reviewed through our Death Review Committee we actually have
20 victims who've left the perpetrator. You know, they've changed
21 their phone number, you know, the perpetrator may not know where
22 they live but they always know where they're going to work every

1 day.
2 So we've had a number of cases where the workplace ... not
3 only the victim is in danger but her workplace, because the
4 perpetrator goes to her workplace and threatens or, in fact,
5 we've had homicides that have taken place at the workplace. So
6 those are cases where you're obviously worried about, you know,
7 multiple homicides and third parties. I mean, obviously one
8 death is one too many but the concern is that everyone is in
9 danger.
10 So it's led to some ... obviously in larger workplaces, you
11 know, for example, a school board, a teacher can be reassigned
12 to a different location or, you know, could work from home,
13 depending on the circumstances. So there's many more remedies
14 that workplaces now think about and certainly in high risk
15 situations.
16 **Q.** Right. Okay. Your *CV* obviously discloses that apart
17 from testifying at inquests and inquiries you've also testified
18 and been qualified as an expert at various levels of court in
19 Canada and in the United States and on page 5 lists some of the
20 areas that you've been qualified as an expert in.
21 I see that obviously the terminology has changed over the
22 years but for our purposes today you've been qualified as an

1 expert in the area of battered wife syndrome, domestic violence
2 against women, exposure to domestic violence, prediction of
3 dangerousness and lethal violence, and patterns of abuse by
4 batterers, some of the most relevant ones to what we're looking
5 at here today.
6 **A.** Yes.
7 **Q.** Any sense of how many times you've been qualified as
8 an expert to testify in various courts?
9 **A.** I've been at this for well over 40 years, I would say
10 hundreds of times, I haven't kept track. You know, when I began
11 it was more informal within the Family Court where I'd be
12 testifying on cases that deal with young offenders, so I'd be
13 testifying going back to 1975. So it would be hundreds of
14 times, either in the criminal context, Family Court context or
15 civil context.
16 **Q.** Obviously, I won't go through them because they're
17 numerous, but you've had a number of grants for various research
18 projects over the years, including, as we've discussed,
19 significant research funding for the Neighbours, Friends and
20 Family Program, the Ontario Women's Directorate Learning
21 Network, the Domestic Violence Homicide Prevention with
22 Vulnerable Populations, the Knowledge Hub funded by the Public

1 Health Agency of Canada, those have all been research grants of
2 $1-million, I guess, or over $1-million?
3 **A.** Yes.
4 **Q.** And your *CV* also contains a list of the research work
5 that you've done both in textbooks ... chapters in textbooks and
6 various papers that you've written over the years. A couple of
7 areas of interest for us here.
8 You've done some research I take it over the years or
9 looked at, the issue of risk assessment and risk prevention and
10 the various instruments that are used or have been used or
11 continue to be used in that area to attempt as best you can to
12 predict domestic violence and to prevent it?
13 **A.** Yes. Part of our major grant, the Domestic Homicide
14 Prevention with Vulnerable Populations, we actually surveyed
15 hundreds of practitioners in different sectors - police, mental
16 health, victim advocates, child protection, and actually
17 surveyed them on what instruments they use if any. So we've
18 published articles that suggest that there's no consistent
19 practice across Canada; that different professionals either use
20 no instrument whatsoever and just trust their own gut instincts,
21 intuition. Others use one of many different tools or some even
22 adapt a tool for their own purposes within their organization.

1 So it's all over the map.

2 **Q.** Right. Okay. And we'll talk a little more about that
3 as we go on, but I'd like to talk to you a bit if I could, again
4 about your work with the Domestic Violence Death Review
5 Committee in Ontario. You were, your *CV* says, one of the
6 founding members of the committee in Ontario.

7 Can you give us a little bit ... I appreciate that it came
8 out of the recommendations from those inquests, can you give us
9 a little bit of the history about how the Domestic Violence
10 Review Committee in Ontario came into being and how it's evolved
11 over the last 20 years or so?

12 **A.** Yes. Well, the Committee began after the jury
13 recommendations and the Office of the Chief Coroner of Ontario
14 was given the mandate to develop and implement the committee.
15 So initially Myrna Dawson, the criminology professor I mentioned
16 earlier from Guelph and myself were assigned to review all the
17 Death Review Committees, you know, across the US and
18 internationally and develop the initial database. That is, you
19 know, we looked at what are the risk factors we should be
20 keeping track of. So we began with a list of risk factors that
21 were known in the research to be associated with either a
22 domestic homicide or increasing risk of serious violence. So we

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1 worked with that and then the committee began ... actually, our
2 first Chair of our committee was a senior Crown attorney working
3 together with the coroner. And there was a full-time police
4 officer assigned to help gather the information for each case.
5 **(10:30)**
6 We had a multidisciplinary committee, so when we began we
7 had representatives from police, Crowns, family doctor,
8 researchers, probation officer. We also had a survivor. We had
9 a mother who lost her daughter to domestic homicide. So we had
10 a survivor on our committee. So we had a cross section and we
11 began to review cases.
12 And in reviewing cases when we began, it was a paper
13 review. So the police officer assigned to the committee would
14 work with the jurisdiction where the death had taken place. We
15 wouldn't undertake a review until the matter had been cleared
16 with the criminal court. So the matter ... either there was a
17 court finding and we waited until any appeals were over before
18 we took on a case.
19 So, obviously, with those circumstances we were able to
20 review the homicide/suicides faster because there were, you
21 know, no criminal proceedings that were ongoing. We'd have
22 hundreds to thousands of pages for each review. So, for

1 example, there would be, for example, if a homicide/suicide had
2 taken place, you know, in a neighbouring community, we'd have
3 all the interviews the police had done with friends and family.
4 We'd have medical records. We'd have records if Child
5 Protection were involved; Corrections, Probation was involved.
6 Or the officer for the committee would gather information from
7 every source.
8 So through the Ontario **Coroners Act**, you know, the coroner
9 can access every piece of information dealing with the deceased,
10 you know, as necessary for the review.
11 Early on, if we felt we needed more information, we might
12 interview, you know, a surviving family member or friend who had
13 particularly critical information. And then we'd write a report
14 and the report would outline the synopsis of what happened,
15 outline the risk factors that were present in the case, and
16 outline recommendations that we thought would be helpful to
17 prevent a tragedy in similar circumstances in the future. And
18 all the cases reviewed for the year would then be put in an
19 annual report and the annual report would be published and be
20 available online.
21 As we went along, we also ... if there was an individual
22 ... every recommendation had to be directed to a particular

1 body. It could be to a government ministry or it could be to an
2 organization. That would be sent out by the administrative lead
3 for the Death Review Committee and sharing the recommendation.
4 And we'd obviously get responses, you know, from the
5 organization it was directed to as to what they were doing.
6 So just to give you a concrete example, I just dealt with
7 this in the past month. I'm a psychologist and I'm licensed
8 with the Ontario College of Psychologists. We reviewed a case
9 last year that involved a psychologist who was involved in an
10 assessment but didn't direct their minds to the issue of
11 domestic violence and the potential risks that were present.
12 One of the recommendations from our review was the College
13 of Psychologists should remind psychologists about the
14 importance of reviewing issues not only around depression and
15 suicide but also about potential homicidal ideation and risk
16 assessment that may be required.
17 So I mention that because as a psychologist, my College
18 sends out a regular bulletin to all psychologists updating us on
19 changing legislation requirements, changing policies, for
20 example, around COVID and, you know, requirements for in-person
21 versus online counseling or counseling through Zoom.
22 So in the bulletin, there's ten pages dedicated to this

1 homicide and the College says, We want all members to review
2 these recommendations from the Ontario Domestic Violence Death
3 Review Committee. It has the recommendation listed and it has a
4 synopsis of the case listed. So I mention that as just a
5 concrete example of how this information gets communicated and
6 how it drills down to the field level.
7 So, obviously, that's a positive outcome. You know,
8 there's other cases where our recommendations may have fallen on
9 deaf ears and perhaps we can come back to that question later.
10 **Q.** Yeah. I did want to follow up on that, on what the
11 uptake is and how you assess the success. But just circling
12 back to the beginning, you said that when you were tasked, I
13 guess, to formulate the first committee, you looked to
14 committees in other countries. So they have existed outside of
15 Canada, have they, prior to the creation of the Ontario
16 committee?
17 **A.** Yes. There was some work being done in Australia and
18 New Zealand, but most of the work is really in the US. When we
19 began, many US states already had some sort of fatality review
20 committee and they varied widely in terms of how they were
21 instituted. And in the US there's a leading scholar named Neil
22 Websdale who's a professor now, I think, at Arizona State

1 University, and he had a federal grant which was called the, you
2 know, Domestic Violence or Fatality Review Initiative. He had a
3 website and on the website they posted the death review report
4 from each US committee. So some were done state-wide. You
5 know, for example, in California there was one done in
6 individual jurisdictions, in San Diego or San Jose or San
7 Francisco. So they varied widely. But he had a website that
8 was a very useful repository of all the work being done. And he
9 also provided us with technical assistance in developing the
10 Ontario committee.
11 **Q.** Okay. And you said that they were structured
12 differently or the approaches were perhaps different in
13 different areas. But I guess the basic idea of a
14 multidisciplinary group of individuals reviewing as much
15 information as they can about domestic homicides, that's
16 consistent, I guess, across all the committees, is it?
17 **A.** Yes. So it's operationalized quite differently, so
18 there would be some ... just give you a range as an example.
19 You know, some committees, for example, in Santa Clara County in
20 California, you know, they had a shoestring budget. You know,
21 they would review based on very limited reports and they would
22 provide recommendations. There would be a published report, but

1 it would be a very ... you know, I think their reports were
2 never more than 15 or 20 pages. It would be very limited.
3 At the other end of the continuum, Washington State on the
4 west coast, they would have a state-wide review but then they'd
5 also assign somebody from their state-wide committee to convene
6 a local meeting. So, for example, if there was a homicide in a
7 smaller community, let's say Olympia, Washington, outside
8 Seattle, they'd actually convene a meeting and bring people
9 together who had firsthand knowledge; police, mental health
10 professionals, surviving family members. So they would do a
11 local review and that review would then become part of the
12 annual state-wide report.
13 So that's a much more intensive and well-funded process.
14 And they would have a very elaborate annual report available
15 online. And they've also done research on implementation of
16 recommendations and showing some of the challenges with
17 implementation. So I'm just giving you those examples as the
18 continuum from one end to the other.
19 **Q.** Right. And the thinking with Death Review Committees,
20 I take it is that they are perhaps a more nimble or cost-
21 effective, if I can even use that term, way of examining
22 domestic violence, deaths, and identifying risk factors and

1 making recommendations then, for example, an Inquiry such as
2 we're doing here?
3 **(10:40)**
4 **A.** Yes. And it also allows you to track issues over
5 time. Obviously, every inquiry or inquest, you know, is able to
6 go into a lot more in depth ... you know, obviously, your
7 Fatality Inquiry is one of the most thorough ones I've seen
8 across Canada just in terms of the dedication and care taken
9 within this Inquiry and the extent of information.
10 Obviously, you wouldn't be able to do that within an
11 individual Death Review Committee. But you would be able to,
12 over a course of a year or five years, be able to document the
13 deaths. You know, you'd be able to document repeated examples
14 of things that you want to alert the public to and it's much
15 more ... I'm not sure powerful, but it's certainly ... when you
16 can point to a number of cases with the same issues. For
17 example, we have a new Chair for our Ontario Death Review
18 Committee. He's the counsel for the chief coroner.
19 And one of the things that he's hoping to do is look at
20 grouping cases looking at specific issues which we see over and
21 over again; for example, issues around firearms, you know, and
22 firearm licenses and some of the issues that I know this Inquiry

1 is grappling with. So it also allows you to group cases.
2 Next year in 2022, we'll be looking at a number of cases
3 where there's been a child homicide or homicide/suicide related
4 to Family Court proceedings where a couple was separating and
5 there was a dispute about the parenting plan or around what
6 happens with the children. So looking at a number of cases,
7 looking at patterns, so that's one of the things that you're
8 able to do through a Death Review Committee.
9 **Q.** We're going to talk about some of the terminology when
10 we get to the literature review but a domestic homicide
11 obviously has to have a definition. You have to choose which
12 cases are appropriate for the committee and which aren't. How
13 do you define them and how do you choose which ones come to the
14 committee?
15 **A.** Our definition is any homicide that happens within the
16 context of an intimate relationship and intimate violence. We
17 include all victims of that violence, so it could be the
18 intimate partner. In many cases, there could be multiple
19 victims, often children are the most common other victims.
20 There's also third parties. We've had cases reviewed in
21 Ontario where a police officer intervened and was killed in the
22 line of duty. So we would consider the homicide of that officer

1 under our definition of domestic homicide. We also see cases
2 with third parties, a new partner, you know, extended family
3 members. So the definition for us is any death in the context
4 of domestic violence.
5 We've also, over time, there's some cases where somebody
6 might have died but didn't because of a radical immediate
7 medical intervention. Just take an extreme case, we had a case
8 of a woman who was shot at with a crossbow and a rifle. She
9 survived. Her partner killed himself. But we reviewed that
10 case because for all practical purposes, you know, obviously it
11 was attempt homicide but it was so significant and severe that
12 she might have died. And, you know, so those are more extreme
13 cases we may have taken on.
14 There's also committees ... we don't do this in Ontario.
15 There's also cases where there's homicide reviews related to a
16 victim suicide, so where a victim has been, you know, assaulted
17 many times over the years. Victims, over time, may become
18 depressed, hopeless, suffer from not only mental health issues
19 but addictions. They may eventually kill herself, but her death
20 is a result of years of domestic violence. So there's some
21 jurisdictions that may look at those cases. We don't in Ontario
22 and no other Canadian committee looks at those cases, but that's

1 been a subject of debate.

2 **Q.** Right. Okay. You listed the various sources of
3 information that you would have and they're extensive. But you
4 said that if you need additional information, that can sometimes
5 be facilitated or you can ask for additional information?

6 **A.** Yes. So we have a secure site where we'd receive the
7 information and the administrative lead for the Death Review
8 Committee would ask us to review the case and prepare a summary
9 two weeks before. So, for example, I have two cases assigned
10 for our December meeting. I've had the information since
11 September and I'm reminded that as I do a review if I need
12 additional information, I should reach out.

13 For example, in reviewing the information we may come
14 across something where a friend says that the victim had been
15 seeing a counselor at a particular agency. So I would contact
16 the administrative lead and say, you know, Can we access the
17 records from this counseling agency that's named on page 550 in
18 the documents? So we would get additional information.

19 **Q.** Okay.

20 **A.** Sometimes we get additional information from ... if
21 the case has been to court, the Crown attorney may have
22 additional information in terms of a presentence report or

1 additional background information about the perpetrator that's
2 publicly available. So we search out whatever is possible.
3 **Q.** Do you sometimes experience resistance in attempting
4 to get information to consider?
5 **A.** There's no resistance with the **Coroners Act** because
6 the police ... you know, we've actually had cases where, for
7 example, a mental health professional, because of obviously our
8 training about confidentiality, indicates they don't want to
9 release the file but obviously with the **Coroners Act**, the
10 coroner has ability to seize every file dealing with the
11 accused. So there's some ... and, again, there's maybe
12 additional resistance or questions, but obviously when
13 professionals understand the law that it's not really optional,
14 then obviously the information gets shared.
15 **Q.** Right. And I neglected to ask you, but you said it,
16 obviously the Ontario committee is formulated under or under the
17 jurisdiction, I guess, or authority of the **Coroners Act** in
18 Ontario?
19 **A.** Yes. And we have no regulation dealing with Domestic
20 Violence Death Review Committee per se. What we have is that
21 the coroner, you know, at any time can call on experts to assist
22 in any investigation. So our Domestic Violence Death Review

1 Committee and there's also a Child Death Review Committee
2 operates under that mandate and, you know, internal structure in
3 terms of their procedures and policies.
4 **Q.** Okay. And I was going to ask you that. There's also
5 a Child Death Review Committee in Ontario, as well, is there?
6 **A.** Yes.
7 **Q.** Has it been in existence as long or is it a more
8 recent development?
9 **A.** I'd have to look that up. I think it's been around
10 for a number of years. I can't give you the specific date.
11 **Q.** Right.
12 **A.** But I'm sure it's been around for at least 20 years.
13 **Q.** Right. And you said that if the domestic homicide
14 results in a criminal proceeding, you have to wait for the
15 criminal proceeding to conclude before you would examine the
16 case at the committee?
17 **A.** Yes. So there's some cases who ... obviously, many of
18 the cases are resolved in the criminal justice system. Some
19 happen more quickly with a plea agreement where someone is
20 pleading guilty to second degree rather than first degree or
21 manslaughter. And those may come to us more quickly. And
22 there's some where there's an extensive trial. So that may be,

1 you know, three or four years. And some that are appealed where
2 we may not see it for five years or more.
3 **Q.** I had marked as, I believe, Exhibit 339, the 2018
4 Domestic Violence Death Review Committee Annual Report. Perhaps
5 we can bring that up.
6 **EXHIBIT P-000339 - DOMESTIC VIOLENCE DEATH REVIEW COMMITTEE -**
7 **2018 ANNUAL REPORT**
8 So this is the type of annual report that the Committee
9 would produce each year, would it?
10 **A.** Yes. And this is, unfortunately, our most recent one.
11 We're two years behind. I think COVID slowed us down and so
12 we're just in the process of publishing our 2020 and '21 report.
13 So we're combining two years because we're behind. But this is
14 the most recent published one.
15 **(10:50)**
16 **Q.** Okay. And on this one, for example, on page two, I
17 think, of the report, the Committee make-up is listed there for
18 that year, for 2018. And I see there are a variety of different
19 professionals. Your Chair at that time was the provincial nurse
20 manager. There's academics, police, social workers, a variety
21 of different professionals that bring different points of view
22 to the Committee work?

1 **A.** Yes. It's a very dynamic ... we have very dynamic
2 meetings. We have, you know, there's different perspectives.
3 We often, you know, debate issues either around recommendations
4 or risk factors in terms of making sure that we're clear on the
5 presence of risk factors.
6 **Q.** So I want to ask you about how you identify the risk
7 factors. You currently, I understand, have a list of 41, I
8 believe, risk factors that you see in domestic homicides or, I
9 guess, that you've seen repeatedly in domestic homicides. Is
10 that correct?
11 **A.** Yes. I think when we began in 2003 and, again, I know
12 this is from my memory. I think we had 35 or 37 risk factors.
13 Over the years, we have added risk factors when we've seen
14 issues repeatedly that aren't properly captured. Before we'd
15 add a risk factor, we would review the literature to ensure
16 that, you know, we're not just coming up with something as a
17 Committee; there's a scientific basis, you know, to add that
18 risk factor.
19 So the Committee members so, for example, an individual
20 review, we are asked to review the case and submit a report two
21 weeks in advance of the meeting to make sure everyone can review
22 the reports. For example, we have a December meeting coming up

1 and there's six or seven cases on the agenda.
2 When we do a report, we get a copy of the risk factors,
3 which we'll come to later, and we have to indicate which ones
4 are present and then we have to indicate what our source of
5 information was that we have to indicate it was in the police
6 report or indicate there was a report of a sister or parent of
7 either the perpetrator or the victim in the case.
8 And then we formulate recommendations and we get asked to
9 draft recommendations. The recommendations we draft have to be
10 directed at someone. It can't be just some idea. It has to be
11 a recommendation. We have to identify a government ministry or
12 a body or an organization that would be asked to implement the
13 recommendation. And then we also get asked to provide some
14 rationale; how does our recommendation relate to the facts of
15 the case. So those are our requirements in our review.
16 **Q.** So the risk factors that you have on your list now,
17 the 41 risk factors, you say those all have to been shown in the
18 literature to be significant as risk factors in predicting
19 domestic homicide, is that correct?
20 **A.** Yes. There has to be some association of that factor,
21 you know, with, you know lethal domestic violence but domestic
22 homicide. There has to be a study. Now I'm using the word

1 "association" because obviously, in any case, it's rare that
2 there's one factor, you know, so obviously a lot of the research
3 would be multiple factors. I'm sure we'll come back to that
4 point when we look at risk assessment tools.
5 **Q.** Right. So is there a debate or significant discussion
6 if someone wants to add a risk factor or designate a risk factor
7 as appropriate for the list? I'm just curious how that comes
8 about.
9 **A.** Somebody raises the issue. Someone says, We're seeing
10 a lot of cases and we haven't really captured that risk factor
11 and it's important it's in the literature. So it would be
12 proposed. We'd go away for the next month or so and we'd
13 research it to see what do we know about that factor? And then
14 it would be presented. And then we'd obviously have consensus
15 about whether to add it or not.
16 **Q.** I see from your ...
17 **A.** So we ...
18 **Q.** Go ahead.
19 **A.** Yeah.
20 **Q.** No. Go ahead.
21 **A.** No. That's ... and so I think there's ... and, again,
22 I think there's a couple of the factors I think near the end I

1 think may have been added. One is on victims' intuitive sense
2 of fear. So we've seen that repeatedly. And that's certainly
3 the literature. And then we also added victim vulnerability as
4 a factor because we've seen circumstances in which obviously the
5 perpetrator's behaviour was obviously a major issue in the risk
6 he posed. But we also saw victims who were in a very vulnerable
7 state, unable to reach out for help due to a number of
8 circumstances. And so that's another example of a factor that
9 we thought was important to include.
10 **Q.** Do you know if other Death Review Committees use
11 similar lists of factors as Ontario does or do they differ from
12 jurisdiction to jurisdiction?
13 **A.** My sense is there would be 80 percent overlap, that
14 there's probably ... for the most part, there's common risk
15 factors that you'd see across every jurisdiction. There may be
16 some that are unique to us, but I'm not sure I could point them
17 out. There's a lot of variability. But, again, for the most
18 part, it's overlapping.
19 **Q.** Are any particular ... well, let me ask you this.
20 When you examine a case, obviously you have your list of risk
21 factors and you, as a Committee, determine how many of them are
22 present. And I assume there's some discussion and debate over

1 that whether a particular risk factor is present. But when you
2 come to a decision, is there a particular number of risk factors
3 that the presence of which become significant to you as a
4 Committee?
5 **A.** Over the years in our Committee, we've designated
6 seven risk factors as a case that appears predictable and
7 preventable, you know, certainly with hindsight, so seven was a
8 cut-off. It's an arbitrary number and it's the one the
9 Committee decided there's such an overwhelming number of risk
10 factors that it's one that should be known to the general public
11 and should have been known to professionals involved that
12 there's significant risk present.
13 And in our annual reviews, we found that at least 70
14 percent of our cases, so seven out of ten domestic homicides are
15 preceded by seven or more, you know, well-known risk markers.
16 So that's what we see over and over again. And we emphasize
17 that point because to the general public, to a layperson when
18 they read about domestic homicide, you know, there's often
19 attitudes which are not very helpful.
20 And some of those attitudes are things like, you know, This
21 happened out of the blue, nobody could have seen this coming,
22 or, Anybody can kill anybody and you can't really stop them.

1 There's nothing you can do or, you know, it was an act of
2 passion and, you know, what can you do about it anyway.
3 So there's a lot of reactions we get in the general public
4 about somehow being somewhat fatalistic about this, which is
5 sort of a hopeless, negative attitude. And our Committee is of
6 the opposite view. In fact, domestic homicide is the most
7 predictable and preventable of any homicide and the patterns we
8 see over and over again, you know, want us to go to the nearest
9 mountain and shout out loud, you know, This didn't have to
10 happen. You know, there's so many warning signs. What we have
11 to do is look at the risk factors and look at the missed
12 opportunities to intervene.
13 **Q.** Right. And so the number seven seemed appropriate to
14 the Committee given that that many are present in, you said, 70
15 percent of domestic homicides?
16 **A.** Yes. And, again, it's somewhat arbitrary. You know,
17 there are cases where ... we have a lot of cases with older
18 couples in failing health, you know, mental health/physical
19 health, you know, where there's no history of domestic violence,
20 no separation, but there's significant depression and
21 significant sense of hopelessness and talk of suicide. So there
22 may be only two or three risk factors, but in those cases they

1 may be critical.

2 So, obviously, the absolute number I think is important to
3 recognize because the more risk factors, you know, obviously the
4 greater the risk. But there may be others that are, you know,
5 important even though there's a smaller number.

6 **Q.** Do you weigh particular risk factors more heavily than
7 others?

8 **(11:00)**

9 **A.** A risk assessment tool may weigh risk factors some
10 more heavily than others. In terms of the Death Review
11 Committee, we don't weigh them differently but we certainly, you
12 know, would have a top ten. So I think in the report, I think
13 it's in the report that you had on the screen earlier, we list
14 the most common risk factors, you know, we've seen that year or
15 over time.

16 **Q.** Right. I've seen that in the report and in the
17 PowerPoint. I just happen to have the annual report here in
18 front of me again and on page 15 of the annual report there's a
19 list of the frequency of common risk factors in domestic
20 homicide cases which we can bring that up, perhaps, just to have
21 a quick look at it. We're going to go through the risk factors
22 individually but this gives us a sense that some are more

1 prevalent than others.

2 So, for example, on that list the most common from 2003 to
3 2018 was a history of domestic violence, current or past. That's
4 the risk factor that you see most commonly in domestic
5 homicides, at least during that period of time?

6 **A.** Yes.

7 **Q.** And the prevalence of particular risk factors, I
8 suppose goes up and down a bit but does the overall list, I
9 guess the ranking if you will, does it stay fairly consistent?

10 **A.** Yes, there may be some variability in terms of whether
11 something is third or fourth and changes but I think the overall
12 factors are consistent. Certainly prior history of domestic
13 violence and actual or pending separation tend to be the most
14 common. That one is critical because on two points. One, the
15 word "pending" is important because sometimes, you know, a
16 couple has decided to separate but they haven't separated yet.
17 You know, we see many couples where they're already seeking
18 legal advice, you know, they may not be able to afford to move
19 into two homes, they may be living in separate bedrooms in the
20 same home, sleeping apart but they're planning on leaving. You
21 know, one partner may be accepting that separation more than the
22 other partner is accepting that as a reality, so the period of

1 separation is critical and we see that repeatedly.

2 **Q.** Right.

3 **A.** I'm not sure if you want me to go through any of those

4 but those are certainly ...

5 **Q.** Well, actually we have the risk document, the list of

6 them, which we'll bring up in a moment and we can talk about

7 them individually but it is interesting on the particular list

8 that there's before us, history of domestic violence is the most

9 common, actual or pending separation, perpetrator depressed and

10 those are the top three, I guess, most common risk factors that

11 you see according to that particular list in your 2018 Annual

12 Report?

13 **A.** Yes.

14 **Q.** So I understand, the cases that get reported and

15 summarized in the annual report, are those only the cases where

16 there are seven or more risk factors present or do you do a

17 summary of each of the cases that you've examined that year?

18 **A.** We do a summary of every case whether there's risk

19 factors, whether there's one or no risk factors and whether, you

20 know, even cases where there's no recommendations. I mean,

21 there are some cases where, you know, a family is not involved,

22 you know, with the police or healthcare or mental health

1 services and there's minimal risk factors. The family is very
2 isolated and there's really, you know, no recommendations we can
3 make for that case and no risk factors. So those cases do exist
4 but they're rare in the minority of cases.
5 **Q.** In most cases, once you've identified the risk factors
6 and discussed them as a Committee, is it fair to say typically
7 you will come to some recommendation or recommendations for
8 particular agencies, government departments, what have you, in
9 most cases?
10 **A.** Yes. And certainly, and we'll perhaps come back to
11 that, certainly probably one of the most common ones is public
12 education, you know, friends, family, neighbors, co-workers is a
13 very common recommendation.
14 **Q.** Right.
15 **A.** And obviously the number of recommendations directed
16 to police or mental health professionals or Child Protection so
17 we have a number of ... there's repeated themes and we'll
18 probably come to that later on.
19 **Q.** Okay. And I take it in some cases you said there may
20 be no new recommendations. Do you sometimes refer back to
21 recommendations you've made previously that need to be
22 reiterated or about which people need to be reminded?

1 **A.** Yes, we either repeat an old recommendation and we
2 make, you know, cross-reference to the former recommendation.
3 Sometimes we take the recommendation and we fine tune it so we
4 add something to the recommendation to clarify and perhaps be
5 more detailed in terms of how to implement the recommendation or
6 what are critical components.
7 **Q.** That was something I was wondering about as well
8 whether you tend more toward, I guess, the broad or the specific
9 when it comes to recommendations, I assume it's a little of
10 both. Sometimes recommendations may be more detailed, some more
11 general?
12 **A.** Yes. I mean it has to be detailed enough that if a
13 government ministry receives it or a professional body, it has
14 to be something that they can act on so it can't be too vague.
15 So we've certainly, over the years, learned to be more specific
16 and detailed as to what the recommendation is. And some things
17 change, I'll just give you one concrete example. Obviously for,
18 you know, a lot of domestic violence relates to dating violence,
19 you know, including adult relationships. And over the years one
20 of the new trends we've seen is adult couples meeting online and
21 cases where there's domestic homicide in cases where people have
22 met online so we've had to be more specific and keep up with not

1 only technology but keep up with dating relationships and try to
2 be more specific about things that we wish dating sites would do
3 in terms of screening people or warning people in appropriate
4 circumstances. So that's an issue that we're currently
5 struggling with.
6 **Q.** Right. And the recommendations, obviously, are not
7 binding, they are recommendations. You've touched on this
8 earlier. Do you have a way to assess or audit, I guess, or
9 analyze how successful you are in having recommendations
10 accepted and acted upon?
11 **A.** The short answer is no, the long answer is we're
12 working on it. I think our Committee, for a number of years,
13 has talked about the importance of auditing the recommendations
14 and actually, you know, looking at a copy of the responses we've
15 gotten and look at the extent of which recommendations have been
16 properly implemented. So that's something that's certainly, and
17 again, I can't speak for obviously our chief coroner and I can't
18 speak for the Chair, as much as I'd like to, but certainly a
19 priority for the coming year is doing an audit.
20 And I'm currently going to launch a new grant where we're
21 hoping to follow up on a number of recommendations particularly
22 related to children to understand the recommendations that

1 haven't been implemented and understand what the resistance is,
2 whether it's lack of training, funding, or lack of
3 collaboration. So that's certainly a priority issue and one
4 that's been identified repeatedly by our Committee and other
5 committees.
6 I would say just in brief, my sense is that I would say the
7 majority of recommendations we do get a response and individuals
8 or ministries indicate what they're doing in the area and some
9 recommendations may have fallen on deaf ears either because of
10 the challenges with funding or legislation. But I would say our
11 Chair and our administrative lead, does share a number of
12 responses and some are encouraging and some are more
13 discouraging.
14 **Q.** Right, as one might expect depending on to whom
15 they're recommended you might get different reactions?
16 **(11:10)**
17 **A.** The hardest one, the hardest response we get when we
18 point a recommendation, sometimes we get a response that says
19 something like, Thank you very much for your recommendation,
20 we're already doing this and that's always a challenge because
21 sometimes, certainly in a province as big as Ontario, sometimes
22 what's being described is happening but it's only happening in a

1 couple communities and it's not happening on a widespread basis
2 in terms of, you know, for example rural and northern
3 communities and so it's not implemented in a comprehensive,
4 consistent way so those are more challenging responses.
5 **Q.** Right. How do you respond to it when you're being
6 told it's being done but you know it may not be done across the
7 board in the whole province?
8 **A.** We don't really ... we don't have a formal response to
9 those so again it's, I'm not sure, those don't come back to the
10 Committee in terms of a second response, you know, I can't speak
11 to what the Chief does or our Chair but clearly as you said in
12 your question, they're not binding but I will say that thousands
13 of people download the annual report and I do think, for
14 example, there's organizations that are intimately involved in
15 domestic violence on a daily basis, for example, you know,
16 police chiefs, you know, regional police chiefs or a police
17 college. I know they download the reports, they share them, you
18 know, certainly with senior officers, you know. Ontario
19 Provincial Police take the recommendations and I know there's
20 usually committees internal to policing that are working on
21 implementing some of the ideas that have been raised.
22 And certainly with, you know, shelters, victim advocates,

1 they certainly look at the recommendations and try to look at
2 what they can do differently.
3 So I think there's active uptake but because they're not
4 binding, I can't speak to what happens after someone doesn't
5 respond or says something's happening when we know it's not
6 really happening consistently. I think, and I hope I don't
7 regret saying what I'm about to say, but I think people ignore
8 recommendations at their peril because if there's a
9 recommendation and there's a strong basis for it and someone
10 ignores the recommendation and then the same thing happens a
11 year later or two years later, I think difficult questions are
12 going to be asked about, you know, certainly family members then
13 ask the question.
14 You know, family members are the strongest advocates as I
15 know you know within your own Fatality Inquiry, family members
16 want questions answered, you know, why did this happen and what
17 can we do to prevent it. If a family member deals with a death
18 due to domestic homicide and they do their own research and they
19 find out the Death Review Committee has done two or three
20 similar cases and made recommendations, they'll be asking the
21 tough questions about why did this death have to happen, you
22 know. Why didn't, you know, somebody do something or why wasn't

1 this implemented?

2 **Q.** Right.

3 **A.** So the general public and family members can become
4 very strong advocates on these issues.

5 **Q.** The discussion at the Committee about whether to make
6 a recommendation or how to formulate it, I assume sometimes is a
7 very robust one. There is, I would assume, sometimes
8 disagreement at the Committee, is there, about what to
9 recommend?

10 **A.** Yes. They're often very lively discussions and
11 arguments. I would say sometimes it's just the Committee works
12 to draft a recommendation in clear language, trying to make sure
13 it's comprehensive. So it's like having a recommendation
14 drafted by one person and then edited by 11 others so people may
15 want to add wording or focus to make it clear. And sometimes
16 there's a question about whether something's practical and I can
17 give you a very clear example.

18 One of the recommendations we've made repeatedly is a
19 recommendation that when the police intervene in a case, a
20 domestic case, that there should be a risk assessment done
21 whether or not charges are filed or not. So that's been a
22 repeated recommendation and that's led to a lively discussion

DR. PETER JAFFE, Direct Examination

1 because some police officers will say it's not realistic because
2 there's so many domestic violence calls, you know, where there
3 may be no charges, where there's no basis for the police to have
4 reasonable and probable grounds that an assault took place and
5 they look at it more as a, you know, a troubled family or, you
6 know, a domestic problem, but there's no criminal charges.
7 And our Committee has repeatedly recommended that you don't
8 need a charge to do a risk assessment. If you're getting called
9 to a case, you know, where's there's, you know, a number of red
10 flags, that in itself should lead to some risk assessment and
11 more detailed interview with the individual who called.
12 So, for example, in Ontario, I use the example because it's
13 one of the more controversial ones, the Ontario Provincial
14 Police, have that in their policy that they have to do a risk
15 assessment if there's a domestic call independent of whether
16 assault charges are laid.
17 I'd say municipal and regional police would only be doing
18 risk assessment if charges are filed. So it's still an example
19 where there's debate and some division and as recently as last
20 month I've had conversations with three major police services
21 about this very issue and certainly the police service struggles
22 on how to do this for every call.

1 I have proposed, this is an academic speaking so I'm not
2 speaking on behalf of our Domestic Violence Death Review
3 Committee, I have proposed informally that these cases should
4 be, if there's red flags, if there's no charges laid but there's
5 a history of other calls and there's red flags, you know, such
6 as a separation or presence of weapons then perhaps there should
7 be a risk assessment done. So that's an area where there's
8 active discussion and debate.
9 **Q.** Just to give us a sense of in the 2018 report, I have
10 just picked one case that you've summarized just to give us a
11 sense of how recommendations may look in a particular case so
12 I'm looking at page 44 of the 2018 Annual Report which is
13 exhibit 339. And just at the bottom and again I just picked
14 this one but it's 2018-10. The facts as summarized in that was:
15 This case involved a homicide of a 50-year-
16 old woman by her 49-year-old husband. The
17 victim was in the process of ending the
18 marriage. The perpetrator had access to
19 firearms and was known to be depressed. The
20 victim was more concerned that the
21 perpetrator would harm himself and was less
22 concerned about her own safety.

1 And in that you found 11 risk factors. Facts not entirely
2 dissimilar to ours in that we had a marriage that was in the
3 process of ending, a perpetrator who was depressed and who had
4 access to firearms, and a victim who, although she may have had
5 an intuitive sense of fear, was perhaps more concerned that he
6 might harm himself than that he would harm her.
7 And in this case you've made recommendations, for example,
8 that the College of Physicians and Surgeons develop a mandatory
9 course on domestic violence and homicide. You made a
10 recommendation that:
11 ... the College of Physicians and Surgeons
12 ... provide information on how physicians
13 can begin the process of encouraging
14 patients to relinquish firearms or
15 collaborating with police to remove firearms
16 from a patient's home.
17 And then further down you circle back to earlier
18 recommendations that you have made previously that I take it you
19 felt were relevant in this case as well. For example: "...
20 that every effort be made by family members, friends, and
21 community professionals to have firearms removed from
22 individuals ..." and there are a variety of others.

1 Again, I took this one partially at random although the
2 facts were somewhat similar to ours. This is the type of
3 summary, the type of case you would typically see and I take it
4 the recommendations might often look like this, that they would
5 be to particular regulatory or government bodies, new
6 recommendations and also some older ones, is that, I guess, a
7 fair comment?
8 **A.** Yes.
9 **Q.** All right.
10 **(11:20)**
11 **A.** And what we'd be looking at in particular cases, you
12 know, what professionals were involved that had an opportunity
13 and potentially a missed opportunity to intervene and this is
14 certainly a common theme. We have a number of cases that deal
15 with firearms. I had, both in this case, again that's an area
16 where I think family physicians need to be more aware and need
17 to have a more frank discussion with family members, both with
18 the individual who is depressed but also family members about
19 all the warning signs and the reasons why there shouldn't be
20 guns around and it's important.
21 Actually, as I read this, I'm just thinking I reviewed two
22 cases in September, both of which involved individuals who were

1 actually gun collectors and had multiple guns in their home, one
2 belonged to a gun club. Both individuals had mental health
3 problems. One was extremely depressed and suicidal. Both had
4 adult ... they were older individuals who had adult children,
5 had regular contact with them and no one had talked about
6 removing the firearms and any physicians who were involved
7 hadn't really addressed that issue so it sort of was shocking to
8 me in reading it.
9 Actually just this is more an aside, I hope it's helpful,
10 but when I reviewed those cases I actually went to look up all
11 the information available, you know, from the RCMP in terms of
12 gun legislation and registration to own a gun and also each
13 province, as you know, implements ... has its own firearms
14 officer that's responsible in that jurisdiction for that
15 province or territory and I did a search online in Ontario to
16 see what was available for the general public about concern
17 about somebody having a firearm because of, you know, mental
18 health issues, depression, domestic violence and I could find no
19 public information. I could find no public information
20 available on websites. I found information available about how
21 to get your gun back but there was no information about concerns
22 for friends and family.

1 And actually, on that issue, because of the police training
2 I do at the Ontario Police College, I did reach out to find out
3 about whether it's information that's accessible and I'm now
4 hoping to, this is outside of my work on the Committee, to look
5 at what can be done, for example, our Neighbors, Friends, and
6 Family Campaign to include information about firearms and the
7 importance of, you know, notifying the police, not waiting until
8 you have to make a 911 call but actually calling the police and
9 say, you know, There's no crisis today but I'm worried about my
10 husband, I'm worried about my brother, I'm worried about the
11 level of depression and talking about suicide, I'm worried about
12 access to weapons and intervening on a more planned basis rather
13 than waiting for a point of crisis.
14 **Q.** Right, okay.
15 **THE COURT:** Mr. Murray, if this is a good spot I think
16 we will take a morning break.
17 **MR. MURRAY:** Sure.
18 **THE COURT:** Dr. Jaffe, we would normally take a morning
19 break and we try and take it around our time 11:15 so I think
20 we'll follow that practice today and we'll break until maybe 20
21 to the next hour, how's that?
22 **A.** Yes, thank you, Your Honour.

1 **THE COURT:** All right, we'll come back then. Thank you
2 very much.
3 **COURT RECESSED (11:23 HRS)**
4 **COURT RESUMED (11:44 HRS)**
5 **THE COURT:** Mr. Murray?
6 **MR. MURRAY:** Thank you, Your Honour.
7 Dr. Jaffe, I thought it might be helpful ... I'm not sure
8 the best order to do these things, but I thought it might be
9 helpful for us to have a look at some of the risk factors right
10 now and just have a discussion about them. And we have a few
11 questions about them, just how maybe they're interpreted and so
12 forth.
13 So we have your list of risk factors marked as Exhibit 345,
14 if you can bring that up, and these are the 41 risk factors that
15 we spoke about earlier that the Committee considers. And I'd
16 like to go through these but before I do, obviously some of
17 these risk factors are, one can tell by looking at them, some of
18 them are static and some of them are more dynamic. I take it
19 that's correct? Some of them really can't be changed and some
20 change over time. Is that correct?
21 **EXHIBIT P-000345 - ATTACHMENT B - JAFFE REPORT - DVDRC RISK**
22 **FACTORS - DISPLAY**

1 **A.** Yes, that's correct.
2 **Q.** Obviously, you're looking at them for the purpose of
3 the Committee. If a particular risk factor existed at any point
4 in time prior to the homicide it would be a yes, I guess, or
5 that would be a positive? Is that correct?
6 **A.** Yes.
7 **Q.** Okay. So a couple of questions, obviously.
8 Perpetrator was abused and/or witnessed domestic violence as a
9 child. I guess this would be dependent ... the ability to which
10 you could make a determination on this one would be dependent on
11 whether you had some historical background or biographical
12 information about the perpetrator. Is that correct?
13 **A.** Yes. So usually that would either be in the clinical
14 notes or clinical findings if the individual was seen by a
15 mental health professional or it'd be the reports of the family
16 or the individual themselves telling other people about their
17 childhood.
18 **Q.** Right. Are there occasions where you have less
19 information about the upbringing of a perpetrator or the
20 childhood?
21 **A.** Yes. So we would leave that out. Actually, this is
22 an aside, but from a research perspective, we've been debating

1 about whether we put present, absent, or unknown. Because
2 sometimes the answer is really unknown because we don't have
3 information one way or the other, especially in cases where the
4 individual has not had contact with helping systems.
5 **Q.** Right. Okay, so obviously, there's a difference. If
6 you know that a risk factor is not present it's a no, but there
7 may be circumstances where it's simply unknown and you can't say
8 one way or the other.
9 **A.** Yes.
10 **Q.** Okay. Dropping down to Family and Economic Status.
11 The youth of the couple. It's, I guess, statistically
12 significant if the victim and perpetrator are both between the
13 ages of 15 and 24 in the relationship?
14 **A.** Yes, it's the highest risk group in Canada in terms of
15 domestic violence and domestic homicide.
16 **Q.** And that's if both of them are between 15 and 24 or
17 just ...
18 **A.** Yes.
19 **Q.** Okay. All right. And just below that, age disparity
20 of the couple. If there is a significant age disparity, which
21 you've designated or indicated is nine years or more, that nine
22 years comes from the literature, does it? Is that typically the

1 point, I guess, the age difference where the risk factors
2 increase?
3 **A.** The research that's been done on age difference looks
4 at nine.
5 **Q.** Okay. Number five is the victim and perpetrator
6 living common law. Do I take that to mean common law as
7 distinguished from being legally married or as distinguished
8 from living separate?
9 **A.** Yes.
10 **Q.** Okay.
11 **A.** No, that's distinguished from cohabitating versus
12 legally married.
13 **Q.** Okay, and we've talked a lot about number six, one of
14 the more common ones, actual or pending separation. So as you
15 said earlier, if there is discussion of separation or if one or
16 both of the parties has taken some steps toward separation that
17 would be potentially a risk factor as well, would it?
18 **A.** Yes, and it's not uncommon to have repeated
19 separations, but certainly separation is a risk factor.
20 **Q.** Right.
21 **A.** And some of the research suggests that there may be
22 six or seven separations before the final break, that often

1 victims leave and they go back for various reasons and leave
2 again. And, again, this comes up later on. Separation is often
3 a process rather than a one-time event.
4 **Q.** Right. Okay. So in a situation where, for example, a
5 couple has had a separation previously, or maybe a couple of
6 separations, but were together at the time of the homicide
7 number six would be present, would it? Or would it depend?
8 **A.** Yeah, I mean it would depend. I mean if the
9 relationship ... if there's clear ... if there was talk of
10 divorce, the relationship is over, they're separating, the
11 homicide follows shortly thereafter, you know, separation would
12 be a factor.
13 **(11:50)**
14 **Q.** Right. Some of these are perhaps more self-
15 explanatory. New partner in the victim's life, child custody or
16 access disputes, presence of stepchildren in the home; that is,
17 any child or children that are not biologically related to the
18 perpetrator. So that's a stepchild of the perpetrator.
19 **A.** Yes.
20 **Q.** Okay, and number ten, the perpetrator is unemployed.
21 Number 11 is excessive alcohol and/or drug use by the
22 perpetrator. So looking at the explanation of this one, it's

1 basically within the last year. Is that sort of the cutoff for
2 that one?
3 **A**. Yes.
4 **Q**. So a person who may ... Go ahead.
5 **A**. And obviously, in this case, in general, there may be
6 sort of a judgment call of the Committee because sometimes
7 there's references about somebody stopping to drink and then
8 falling off the wagon, so to speak, and drinking again, and so
9 clearly there has to be something documented about concerns
10 about this area.
11 **Q**. Okay. All right. So if a person had maintained
12 sobriety for a long period of time and perhaps had had a slip
13 during the preceding year that, I guess I take it from what you
14 say, might be debatable whether that would be one that would be
15 a yes or not?
16 **A**. Yes, we'd have to debate whether there was, you know,
17 clear evidence or not on that issue.
18 **Q**. Okay. 12 is depression in the opinion of a family,
19 friend, or acquaintance, and 13 is depression professionally
20 diagnosed. So first of all, obviously, by its very nature, if a
21 friend, family, or acquaintance indicated that the perpetrator
22 was depressed it doesn't have to be a clinical diagnosis. They

1 simply have to make some reference to that or a description of
2 the person as depressed in their feeling, I guess?
3 **A.** Yes. So it would have to be clear and convincing from
4 what family and friends are saying, because we do have many
5 cases of perpetrators, you know, where everyone says they're
6 depressed in terms of their mood, and they describe it in
7 various ways but they've never gotten the individual to go get
8 help from a mental health professional. So we've tried to
9 capture that. We wanted to have both categories because of the
10 fact that often people haven't reached out and they should have
11 because of the seriousness of their condition.
12 **Q.** Right. Okay. And then if a person has had a
13 diagnosis from a professional of depression, irrespective of how
14 many professionals may have given that diagnosis, that's counted
15 as one factor.
16 **A.** Yes.
17 **Q.** Okay. And then 14 is other mental health or
18 psychiatric problems, the perpetrator having other mental health
19 or psychiatric problems, and you give a number of examples. But
20 basically, I take it, then, any other mental health problem
21 other than depression, any number of them would count as one if
22 any one was present?

1 **A.** Yes. So if they were ... obviously, depression is the
2 most common thing we'd see as a risk factor, but if there's
3 other diagnoses we indicate that as well.
4 **Q.** The list is psychosis, schizophrenia, bipolar, mania,
5 obsessive compulsive disorder. So would personality disorders
6 rise to the level of any other mental health issue that would be
7 a yes?
8 **A.** Yes, and it would have to be formally diagnosed. So
9 it'd have to be in the record.
10 **Q.** Okay. All right. Number 15 is prior threats to
11 commit suicide by the perpetrator, and I found it interesting
12 the comment is, even if the act or comment was not taken
13 seriously by the person reporting it it's nonetheless a positive
14 risk factor. So even if a perpetrator ... it's maybe not the
15 best word to use, but if they appear to be joking about suicide
16 prior to a tragic event, or what seems to everyone to be a joke,
17 that's still a risk factor, is it?
18 **A.** Yes, definitely, and that's obviously a big issue in
19 the field where somebody says something and there could be
20 multiple purposes for saying something. It could be attention-
21 seeking or it could be a control mechanism to try to get the
22 partner to come back into the relationship to arouse sympathy

1 and support. But we take those comments seriously and we
2 suggest other people do as well.
3 **Q.** Right. Okay. Some of these, perpetrator attitude
4 such as obsessive behaviour displayed by the perpetrator, which
5 is number 17 or number 20, misogynistic attitudes by the
6 perpetrator. There's a certain degree of subjectivity, I guess,
7 in interpreting whether those are present or not as opposed to
8 some that are more objective like the age-related
9 characteristics.
10 **A.** Yes.
11 **Q.** Are they difficult to determine whether they're
12 present or to agree whether they're present?
13 **A.** Number 20 you'd have to have clear evidence. You
14 know, you'd have to have comments that clearly, you know,
15 reflect the hatred and disrespect of women.
16 **Q.** Right.
17 **A.** I mean if somebody is indicating that they'd have to
18 show on the record, you know, what the basis is.
19 **Q.** Okay. Prior destruction or deprivation of the
20 victim's property. That could be any property including
21 property that the perpetrator has an interest in, as well, then,
22 could it?

1 **A.** Yes.
2 **Q.** Number 22, history of violence outside of the family
3 by the perpetrator. So that is, say, any actual or attempted
4 assault on any person who is not or has not been in an intimate
5 relationship with the perpetrator. That's even if it is not in
6 any way related to the domestic situation? So, for example, if
7 the perpetrator committed violence at his workplace and it had
8 nothing to do with his partner that would constitute a positive
9 risk factor, would it?
10 **A.** Yes.
11 **Q.** Okay, and 23, history of domestic violence with
12 previous partners, and 24, history of domestic violence with
13 current partner or victim. And we're going to talk about more
14 specifically in a moment about the definition of domestic
15 violence and what constitutes domestic violence, but I take it
16 that doesn't have to be an actual criminal charge or something
17 where the person is convicted of, for example, an assault. If
18 you have evidence of a history of domestic violence of any sort.
19 Is that correct?
20 **A.** Yes.
21 **Q.** All right. Some of these, for example, 25 is prior
22 threats to kill the victim and then 26 is prior threats with a

1 weapon. If, for example, the perpetrator threatened the victim
2 with a weapon that would constitute two separate risk factors,
3 would it, then?
4 **A**. Yes.
5 **Q**. Okay.
6 **A**. I mean 25 is more, obviously, making threats and
7 making comments, and sometimes they're implied. But, again, our
8 Committee would have to agree that somebody hearing that
9 comment, you know, should be concerned about their safety. And
10 26 is very specific, you know, threatening with a weapon.
11 **Q**. All right. I guess I'm just thinking that on occasion
12 there may be overlap where two or more of these might apply, and
13 if that is legitimately the case based on the facts that you
14 have, you could have multiple risk factors from one event, let's
15 say, between the perpetrator and the victim.
16 **A**. Yes.
17 **Q**. Okay. We skip over to number 32, choked/strangled the
18 victim in the past. Our own **Criminal Code** has been amended to
19 specifically address issues of assaults in the nature of choking
20 or strangulation. I take it the literature suggests that that's
21 a particularly concerning form, if I can say that, of domestic
22 violence as a risk factor?

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1 **A.** Yes, it's one of the more consistent ... it's not
2 necessarily on our list, but it's one of the most significant
3 risk factors if someone reports that having happened. I will
4 say, just an aside here, that's one that sometimes is hard to
5 identify because the victim may not have reported that. You
6 know, they may have experienced that but unless the police have
7 asked about that specifically, or in some cases actually gotten
8 medical evidence, it may not be clearly outlined in the history.
9 So I think it happens more frequently than it gets reported.
10 **(12:00)**
11 **Q.** Right. Okay, and again, just looking at, for example,
12 number 34, prior assault on the victim while pregnant. So
13 that's a particular and different risk factor than simply prior
14 assault on the victim. So of more concern, or its own
15 independent risk factor, if the victim was pregnant at the time
16 of a prior assault?
17 **A.** Yes.
18 **Q.** Okay. Number 37, extreme minimization and/or denial
19 of spousal assault history. So I take it there would have to be
20 something from the perpetrator either directly in a statement or
21 something from a witness that suggested that he repeatedly
22 minimized acts of violence or domestic violence against his

1 partner. It couldn't just be one incident, I guess, I take from
2 that, or one comment?
3 **A.** It would have to be something significant in the
4 record where the perpetrator was confronted by a victim or
5 family member, someone and the perpetrator denied what happened
6 or denied the seriousness of what happened.
7 **Q.** Okay. Number 38 is access to or possession of any
8 firearms. That's obviously one that we've discussed and is more
9 straightforward. 39, after risk assessment perpetrator had
10 access to victim. So in that particular set of circumstances
11 where some agency conducted a risk assessment, if the
12 perpetrator has access to the victim there's a greater risk in
13 those circumstances?
14 **A.** Yes, that is a new factor, I think, we added. I'm not
15 sure what year. But certainly once a risk has been identified
16 and somehow there's no safety plan for the victim, or risk
17 management strategy for the perpetrator, and he continues to
18 have access we see that as a risk factor.
19 Actually, a common one we've seen where there's a child
20 custody dispute and there's evidence before the Family Court
21 about a history of domestic violence.
22 **Q.** Yes.

1 **A.** And the court order allows the perpetrator to have
2 regular access to the child without it being supervised visits
3 or supervised transfer or third-party transfer. That would be
4 an example where the perpetrator is still at the victim's
5 doorstep even though there's been a risk assessment and those
6 cases, unfortunately, continue to happen.
7 We have a number of cases where the criminal court has
8 taken the domestic violence seriously. They may be charged.
9 There may be even a conviction that may be for ... or more minor
10 assault. In spite of that, the Family Court is still hoping the
11 parents can work together in terms of co-parenting the children
12 which is pretty well impossible in those circumstances.
13 But the perpetrator continues to have access to the victim
14 even though it's been identified as high risk. And we actually
15 have those cases. Every now and then you might look at this and
16 say, Well, is that even possible? Actually, I did review a case
17 where a woman went to criminal court on charges and she had a
18 specialized Crown attorney. She had a specialized police
19 officer. She had Victims Services. She had a whole circle of
20 support around her as a victim of domestic violence and then she
21 went to a courtroom in the same courthouse, the Family Court,
22 and there was a judge who told her that if she was going to have

1 custody it was still her job to promote access to the child's
2 father. You know, she had to, you know, still find a way to
3 work together and manage this and a homicide happened shortly
4 thereafter.
5 But that's an example where there was clearly risk but
6 somehow the perpetrator still had ongoing contact with the
7 victim.
8 **Q.** So that's ongoing contact whether it's court-ordered
9 or whether it's not, if that access still exists.
10 **A.** Yes.
11 **Q.** The risk is present. Okay. You had said earlier that
12 one of the more recent ones that you've added to the list is the
13 victim's intuitive sense of fear of perpetrator. Even if the
14 victim doesn't have, perhaps, an overt reason or a specific
15 reason why that may be has that been shown to be a predictor of
16 domestic homicide or a risk factor that is present in many
17 domestic homicides?
18 **A.** Yes, and I would say there's extensive research in the
19 US, and maybe I can just elaborate on this point, that suggests
20 that at least half of victims who are killed know they're going
21 to be killed and are desperately seeking support and safety.
22 You know, they tell everyone. You know, they reach out to the

1 police because it's the seriousness. They tell their friends
2 and family. They're clearly concerned and they tell people
3 about the pending doom that they fear.
4 The other half of victims who are killed in a domestic
5 homicide don't see the risk. They see their ex-partner as, you
6 know, perhaps he's going to harm himself. He's annoying. He's
7 harassing. He's got difficulties, but they don't believe that
8 he's actually going to harm them or the children and the major
9 study done years ago by a researcher in the States, Jacquelyn
10 Campbell at Johns Hopkins, did a study and she looked at a
11 thousand domestic homicides compared to a thousand domestic
12 violence where there was no homicide, and this is a pattern she
13 found and this is a pattern that we've seen in our work.
14 **Q.** That 50 percent of victims know or fear that they may
15 be killed and 50 percent not?
16 **A.** Yes, they might see their ... you know, we have people
17 who go to court together, you know, they want to get a
18 restraining order. They find their partner just annoying,
19 harassing, stalking them, and they just want him out of their
20 life but they don't see the risks that are present. And that's
21 where I think we'll come back to this later on, because it's in
22 my report, that it's a point at which ... I think it underlines

1 the importance of third-party professionals and sometimes
2 friends and family saying to somebody, He's not just annoying
3 and harassing, he's dangerous to you and he's dangerous to the
4 kids.
5 So it takes a third party, and we have a number of cases
6 like that. One of our inquests, the Hadley case, we had a
7 domestic violence specialist who responded to a domestic
8 violence call and went through the traditional risk assessment
9 form that the police have in Ontario. And the victim in that
10 case, Jillian Hadley, told the officer, I want him to stop
11 coming around, I want him to stop bothering me, it's nonstop.
12 And the officer actually said to the victim, you know, He's
13 not just annoying and harassing, he's dangerous and, you know,
14 doing the risk assessment, you know, this is what we found and
15 we have to work on a safety plan for you and we have to, you
16 know, make sure that this gets reported, you know, I have to
17 share this with the Crown and we have to make sure that there's
18 clear conditions.
19 So that's a very concrete example, but the important point
20 for me is as professionals, whether you're a police officer or
21 psychiatric or family doctor, although intuitive sense of fear
22 is obviously an important factor to be aware of, you also have

1 to be aware that it's important to do some sort of structured
2 interview, use a tool, because in some cases a victim's life is
3 in danger and she's lived with so much for so long she doesn't
4 see the danger to herself or her children.

5 **Q.** Right. Okay. And the person in that circumstance may
6 not have the intuitive sense of fear despite the ...

7 **A.** Yes, or they've lived ... I think and I'm sort of
8 getting ahead of my evidence, there's comments. I forget which
9 sister said this, but one of them commented in talking about
10 Lionel Desmond commenting on that they had all habituated to
11 this. It's just the way it was. There were so many ... it was
12 a constant ... it was like you're living in a war zone. So, you
13 know, one more shot being fired, you know, doesn't gain your
14 attention it becomes part of ... it's sort of the new normal.

15 So I think there was a comment made by one of the family
16 members that sort of described this phenomenon. It was just ...
17 it was there and they sort of got used to Lionel being Lionel
18 and, you know, "snapping" or whatever the wording was at that
19 time.

20 **(12:10)**

21 **Q.** All right. The final factor is victim vulnerability,
22 which I take it is the most recently added risk factor, and your

1 explanation of victim vulnerability is that the victim may be
2 considered vulnerable due to problems in life circumstances
3 which make reaching out for help more difficult. These may
4 include: mental health issues and/or addictions, disability,
5 language and/or cultural barrier - for example, new immigrant or
6 isolated cultural community - economic dependence, and living in
7 rural or remote locations.
8 I take it when you say this may include those, that list is
9 not exclusive. There may be other ways that a victim may be
10 found to be vulnerable due to their problems and life
11 circumstances?
12 **A.** Yes, and obviously we discuss that as a Committee. I
13 mean some of those definitions are clear, you know, and I can
14 anticipate time in the future when there may be some other
15 dimension that we might, you know, revise the definition, expand
16 it or add other factors in the future.
17 **Q.** Right.
18 **A.** But I think that description captures it and we're
19 always concerned about individuals living in rural or remote
20 communities because it's ... and we'll come to this later in my
21 evidence, but with rural communities it's often harder to get
22 help, harder to get help on a timely basis.

1 **Q.** Right.
2 **A.** We have an upcoming inquest into three homicides that
3 took place in eastern Ontario where a perpetrator killed three
4 former partners all in the same day. The perpetrator has since
5 been convicted of three counts of, you know, first degree
6 murder. But in that case there's elements of rurality, you
7 know, in terms of being ... you know, although the location was
8 two hours away from larger urban centers it's obviously harder
9 to police. Rural areas, it's harder to respond as quickly as
10 you do if, you know, call 911 in London, Ontario or Halifax
11 you're going to get a response pretty quick. It's obviously
12 different in rural communities.
13 And the other reality is that firearms are more common in
14 rural communities. And actually, that women in Canada who are
15 killed by a firearm, killed in a domestic homicide, are more
16 likely to be living in rural communities than urban communities
17 just because of the presence of firearms as a normal part of
18 rural life.
19 **Q.** Right. And on the form that we've been referring to,
20 the final block says other factors that increased the risk in a
21 particular case, specify. Can there be, you know, on occasion a
22 risk factor that's evident to the Committee that may not fall

1 within the 41 very neatly but clearly is significant and worthy
2 of some note? Is that what I take from that?
3 **A.** Yes. There may be special circumstances we want to
4 capture as part of the narrative, but it may not be a formal
5 risk factor. It may be a formal risk factor in the future.
6 One of the ones that we've seen ... there's many, many
7 examples but one is sort of the perpetrator is suffering recent
8 losses. Besides the checkmark potentially for unemployment is,
9 like, recently has lost their job. There may be a death in the
10 family; the perpetrator lost a parent or ... we've had a number
11 of cases that, that would be a theme, that the perpetrator's
12 sense of loss and life is going downhill. And so it may not be
13 captured in detail in the other risk factors, but we might
14 expand on that.
15 **Q.** Right. Okay. You've prepared for us a helpful
16 report, obviously, that outlines a good deal of information
17 about domestic violence and some slides to go along with that.
18 I may make reference to those now if we can start kind of having
19 a look at them. Perhaps we can bring up the slides, the
20 PowerPoint presentation, which is Exhibit 344.
21 And if we go to page 3 you help us with some of the
22 definitions. And I guess the starting point here, obviously,

1 because we've used the term a great deal, is domestic violence
2 and how it's defined. And it may be helpful for us if you were
3 to explain what is contemplated by domestic violence. Because
4 the term is perhaps much broader, or encompasses a great deal
5 more particular activity, than we might sometimes think.
6 So how would you define domestic violence?
7 **EXHIBIT P-000344 - JAFFE - DESMOND FATALITY INQUIRY - POWERPOINT**
8 **- NOVEMBER 3, 2021**
9 **A.** Well, domestic violence and sometimes in my report
10 it's referred to as intimate partner violence, but the terms of
11 interchangeable. We're talking about violence and abuse that
12 happens in an intimate relationship. So that can range from a
13 couple dating in high school to living together for 50 years,
14 being married for 50 years. A man can be the victim. A woman
15 can be the victim. It also can be violence in same-sex
16 relationships, two men or two women in a relationship. So it's
17 really abuse that happens in an intimate relationship.
18 The important point is that it's more than physical. A
19 layperson will think that domestic violence has to imply
20 physical; there has to be a black eye or a broken jaw or broken
21 limb. In fact, domestic violence takes many forms. It's
22 physical, it's sexual, psychological and emotional. It also

1 includes ... part of that can be abuse by technology, constant
2 texting or posting, you know, threatening texts or messages on
3 Facebook. Economic abuse, controlling a partner.
4 And the broadest term now that's used in serious cases is
5 coercive control. And I think we'll come back to that. But
6 coercive control, you know, looks at one person's attempt to
7 control and dominate their partner, you know, through a variety
8 of means and I'm singling out that term because it's now
9 actually part of changing legislation. Coercive control is now
10 in the **Divorce Act**. The **Divorce Act** in Canada was amended the
11 past March. It now includes much broader definitions. It's
12 called family violence in the **Divorce Act** and it includes
13 coercive control.
14 **Q.** And in your report you said coercive control describes
15 a pattern of behaviours to assert control over a person by
16 isolating them from sources of support, exploiting their
17 resources and capacities for personal gain, depriving them of
18 the means needed for independence, resistance, and escape, and
19 regulating their everyday behaviour. That's, obviously, a very
20 broad definition, but that's a term that's ... I guess it's
21 coming to be used more frequently and recognizes certain
22 circumstances.

DR. PETER JAFFE, **Direct Examination**

1 **A.** Yes. The one thing I would just add to that.
2 Coercive control has an impact on victims in terms of
3 potentially engendering fear and concern. But it's also
4 important to note that coercive control doesn't have to be
5 effective. This doesn't mean that somebody actually has
6 control. Somebody is attempting to have control.
7 For example, I have a recent case I'm involved in where the
8 wife is a physician and the husband is a business executive, and
9 there's elements of coercive control, trying to manage things
10 financially, trying to, you know, limit her in terms of work and
11 trying to know where she is at all times. Very jealous and
12 possessive. And in that case, as it unfolds in the court, the
13 lawyer for the husband argues, Well, she still went to work
14 every day, she still talks to her mother, she still has friends.
15 And so I realize when I ... one of the times when I talk
16 with lawyers or the lay public that just because you're
17 attempting to have control doesn't mean you actually do or you
18 actually control every aspect of someone's life. So, you know,
19 coercive control can be something that's attempted but it may
20 not be fully effective to actually control a victim.
21 **Q.** Right. And so the mere attempt would constitute an
22 act of domestic violence or intimate partner violence.

1 **(12:20)**
2 **A.** Yes, and then coming back. The key word is "pattern".
3 Because ultimately although ... you know, certainly within the
4 court system one is focused on what happened on a certain day, a
5 certain event, whether they're a witness to it. When we talk
6 about coercive control we're usually talking about a pattern of
7 behaviour over time with multiple examples.
8 At the end of the day domestic violence isn't just about
9 getting drunk and hitting somebody on a Saturday night.
10 Domestic violence, you know, when we're really concerned about
11 it, is one person's attempt to, you know, control or dominate
12 their partner through a variety of means, including, you know,
13 physical, emotional, and other means.
14 **Q.** So you said a moment ago that there are sometimes a
15 misconception in the general public that domestic violence has
16 to be comprised of a physical assault or maybe a threat, but
17 it's much broader than that. Do you find those same
18 misconceptions sometimes among professionals as well?
19 **A.** Yes. I still think that's common that people are
20 thinking about physical violence. They ask whether, you know,
21 Has he ever hit you? And he doesn't have to hit you to frighten
22 you. You know, so there's many forms of threats, implied and

1 otherwise, you know, that are concerning.
2 I do a lot of work with police, certainly through the
3 Ontario Police College, and with police training one of the
4 things I find, one of the examples I often refer to, is stalking
5 where somebody is stalking, harassing, you know, repeated text
6 messages. Even after clearly when someone's been told to stop,
7 that it's unwelcome attention, contact.
8 And I find that even officers with some experience are
9 reluctant to lay charges related to stalking and harassing
10 behaviour unless there's threats, and I have to point out you
11 don't have to make a new threat, you know, to qualify for
12 stalking and harassing. You know, sending somebody, you know,
13 dozens of text messages after you've been told to stop. You
14 know, posting things, saying things. You know, even if you're
15 dropping off chocolates or flowers those are still, you know,
16 concerning behaviours.
17 So I just mention that because that's an example where, you
18 know, we tend to think about physical violence or a threat of
19 physical violence rather than see the overall pattern and what
20 it's doing.
21 **Q.** Right. We see cases, I guess, in our work where
22 there's repeated communication and it may be a person who's

1 perpetrated an act of domestic violence, and on their face they
2 appear to be benign communications or attempts to reconcile or,
3 I'm sorry, or, I love you, but it's repeated. That may
4 constitute an act of domestic violence as well? Or it could be
5 considered a form of control, could it?
6 **A.** Yes. There's nothing benign in the history, you know,
7 if there's a pattern. I'd also include talking about suicide.
8 It's listed under coercive control, but attempts to control your
9 partner by talking about killing yourself.
10 **Q.** Right.
11 **A.** What that does, it makes the partner feel responsible
12 for you. Because at the end of the day, you know, a wife who
13 hears about a husband who wants to kill himself feels sorry for
14 him, feels responsible, feels that she wants to help him. She
15 doesn't want him to die. She doesn't want to be responsible for
16 someone's death. She doesn't want her children to lose a
17 father.
18 So part of controlling is talk about suicide, threats of
19 suicide. It's an element of control.
20 **Q.** Even if there isn't a real intent to commit suicide if
21 the comments are made.
22 **A.** Yeah, and you don't know. I mean it's obviously ...

1 when someone talks of suicide, says the world would be better
2 without them, obviously, it puts the victim in that relationship
3 ... makes them feel responsible, makes them want to be a
4 caregiver, caretaker to that individual, they don't want them to
5 die.
6 Sometimes it's used as a way of reconciling, that they
7 don't want to be responsible for the death so they reconcile
8 with a perpetrator. Actually, just as an example, in the Laurie
9 Dupont case, the nurse at Hôtel-Dieu in Windsor, her
10 perpetrator, the physician who eventually killed her and killed
11 himself, he talked about suicide repeatedly. He actually had
12 made an overdose and she actually saved his life.
13 And in fact, you know, that was done as a way to get them
14 to reconcile and then obviously he later killed her and killed
15 himself. But that's a pattern we certainly see in high-risk
16 situations, and it has to be taken seriously, and I think both
17 for the general public and professionals, they somehow see this
18 as totally separate. They see depression and suicide talk or
19 suicide attempts as something separate from domestic violence
20 when it's, in fact, very intimately connected.
21 **Q.** Right. Okay. You gave us the definition of domestic
22 homicide, and I think we've touched on this before when we

1 talked about what cases are accepted into the Domestic Violence
2 Death Review Committee. But how do you define a domestic
3 homicide as compared to other homicides?

4 **A.** Well, any death in the context of an intimate
5 relationship and, again, in our research and our work and many
6 researchers, they include third parties, you know, and
7 obviously, that's other family members, children, and
8 professionals who might be intervening.

9 **Q.** Okay. And you've commented on children exposed to
10 domestic violence, that that is a form of child emotional abuse.
11 I know you've studied this, obviously, and it's been an area of
12 interest for you. What can you say about the effect on children
13 having been exposed to domestic violence?

14 **A.** Exposure to domestic violence impacts children's
15 safety and sense of well-being. It often can create emotional
16 and behavioural problems in children. About 40 percent of
17 children exposed to domestic violence may suffer trauma symptoms
18 themselves. And again, that's one thing we certainly learned
19 about post-traumatic stress disorder. You don't have to be the
20 one whose life is being threatened. Witnessing others who maybe
21 had their lives threatened, exposed to violence on a regular
22 basis can give you trauma symptoms.

1 And actually, I'm drawing the analogy to children. In our
2 work we've actually done research with judges and other
3 professionals who were exposed to violence on a regular basis as
4 a part of their daily work. You know, whether you're a judge, a
5 police officer, or Crown attorney, a therapist working with
6 abuse victims. What the research suggests is you develop
7 symptoms of PTSD over time, that it's vicarious trauma.
8 So the symptoms that victims feel then become parallel in
9 what professionals who try to intervene over time. And
10 obviously, the longer you're at this work, you know, there's an
11 opportunity to develop post-traumatic stress disorder. And
12 obviously, now there's much more awareness in terms of services
13 for police and other professionals.
14 **Q.** Right.
15 **A.** Actually, our Attorney General is launching a campaign
16 to support Crown attorneys who do this work and get exposed to
17 graphic evidence on a regular basis. I'm mentioning that only
18 because that's the parallel to me to children. We often think,
19 Well, you know, children, they weren't ... you know, we don't
20 know what they witnessed. But the reality is we don't use
21 "witnessed" anymore. We use "exposure" because it's what they
22 see. It's what they hear. Dealing with the aftermath of the

1 distress in one or both parents.
2 So children can suffer serious harm both in the short term
3 and in the long term. I think I mentioned in my report, but in
4 Ontario if police officers go to a home where there's domestic
5 violence they have a mandatory report. They have to send a copy
6 of the report to the local children's aid society to follow up,
7 because children are considered to be at risk of emotional and
8 psychological harm by living with violence even if no one ever
9 laid a hand on them.
10 **Q.** Okay. You've included a diagram in your report, which
11 is on the next slide, actually. It's called the Power and
12 Control Wheel. Is that a diagram or an illustration that is
13 something that you've created or where does that come from?
14 **(12:30)**
15 **A.** I think there's reference in my report. I have some
16 links to the actual source. So this is developed out of Duluth,
17 Minnesota. So a number of researchers going back a quarter
18 century tried to capture the fact that domestic violence was
19 more than just physical violence, and what they wanted to
20 indicate that really domestic violence often can be one person's
21 attempt to control and dominate their partner through a variety
22 of means. So it may be physical violence. It may be sexual

1 violence. But ultimately it also includes psychological and
2 emotional abuse.
3 **(12:30)**
4 So each of the spokes of the wheel illustrate the various
5 strategies that may be used in whole or in part as a pattern of
6 violence. So again, you don't have to ... this is not a test.
7 You don't have to have all eight elements of the spoke to be
8 involved in efforts of power and control but clearly, you know,
9 some of the common ones are ... you know, without repeating what
10 everyone can see on the slide, it's intimidating somebody from
11 their gestures, smashing things in the house, using emotional
12 abuse, putting somebody down, calling them names, trying to
13 isolate them from friends and family, using jealousy, minimizing
14 their own behaviour once they're called out on what they're
15 doing. Using children about telling somebody, you know, they're
16 going to get custody of the children and the other parent isn't
17 fit. Using economic abuse, trying to prevent somebody from
18 getting to work or not working or being threatened.
19 And, again, this is a very common dynamic that
20 perpetrators, and this may change over time, perpetrators of
21 domestic violence may want to be the dominant partner in the
22 relationship. I mean this is, I'll be clear, this is, you know,

1 how we're socialized as men. As men, we're the hunters,
2 gatherers, we're the ones supporting the family, and our partner
3 may be dependent on us. And when our partner gets a job, goes
4 back to school, tries to upgrade, although it may be welcomed
5 initially, at some point it becomes threatening. And it's
6 especially threatened if you're, you know, in the Desmond
7 circumstances, you know, you have somebody who is certainly
8 proud, you know, rightfully proud of being in the military,
9 serving the country, and then comes home, obviously, you know,
10 damaged from serving the country in terms of clearly having
11 post-traumatic stress disorder and being exposed to the most
12 horrific things any of us could ever imagine. Being unemployed,
13 no longer being in the military, no longer feeling useful. And,
14 in this case, a wife who has gone back to school, got a nursing
15 degree, and starting a job. So that would be very threatening
16 to, you know, the average Canadian male in our image of
17 ourselves, you know, potentially as a breadwinner. Again, I'm
18 generalizing, you know, obviously cases vary but certainly this
19 issue is all over this file review.
20 And then at the top left-hand corner, using coercion and
21 threats. You know, text messages about getting access to guns.
22 You know, threats. Those are very significant issues. So any

1 one of these are an isolated example.
2 If you have the pattern, I think in the Desmond case, you
3 have many of these actively going. And I would say, and I'm
4 getting ahead of my testimony but I'll say it now, and I'll
5 repeat it later, that if somebody had done a thorough risk
6 assessment and interview, either with Shanna Desmond or with
7 Lionel Desmond, you know, in December or early January, January
8 1st and 2nd, and gone over all these things, somebody would have
9 said to Shanna or to Lionel, I'm really worried about you. I'm
10 worried about the pattern. I'm worried about all these things
11 and we need to put in an immediate safety plan or we need some
12 immediate risk management strategies. This can't wait for an
13 appointment a month from now or two months from now. You know,
14 this is significant.
15 But it takes a third party informed about these issues to
16 sit down with them, with both of them, individually. And I say
17 both of them because most men who kill didn't have to end up
18 with that outcome. These aren't inevitable outcomes. These are
19 things where somebody needs to speak to the perpetrator, talk
20 about the path that they're on, and there's going to be
21 consequences, either in terms of ending up in jail or death that
22 don't have to happen if there's help on a timely basis. And the

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1 same thing, obviously, with the victim.
2 **Q.** And that, as you say, a third party who speaks to
3 both, the perpetrator and the victim and perhaps speaks to them
4 independently and learns more about the situation.
5 **A.** And I would say, the one thing I'd want to emphasize
6 and I will come back to this, is also speaking to the
7 perpetrator with care and compassion. It's not like, You're in
8 trouble and you're going to jail for many years, it's more, I'm
9 worried about you, I'm worried the path you're on, I'm worried
10 where all this is going to end. Because if you're a police
11 officer with 10 years' experience or 20 years' experience, you
12 know a lot more about domestic violence, domestic homicide than
13 that victim or that perpetrator. You know, it's their life and
14 they may be getting used to feeling a certain way or thinking
15 certain things. You know, if you're a family doctor and
16 you've seen hundreds or thousands of patients with care and
17 compassion, you can say to, for example, the perpetrator. For
18 example, you know, a physician can say to Lionel Desmond, I'm
19 worried about you. You know, research shows pretty clearly when
20 someone is depressed, having a firearm in the home, you're going
21 to end up eight or 10 times more likely to kill yourself or kill
22 your partner, and firearms are a bad idea, you know. I don't

1 care if you enjoy hunting, you know, you have to find another
2 hobby or interest just because the level of risk, you know. And
3 I think that's pretty critical.
4 It's no different. You know, when I get my annual check-up
5 and my family doctor weighs me, you know, he'll say to me, you
6 should lose weight, you know, and I don't take that offensively.
7 I don't say to my doctor, Well, you should lose weight, too. I
8 listen to my family doctor and I know he is telling me about
9 risk factors. He's said, you know, for every "x" number of
10 pounds, you know, it's going to put you at risk for the
11 following diseases.
12 To me, it's no different than a family doctor sitting down
13 with someone and say I'm worried about you having any access to
14 firearms and here's the research. And the research, it's not
15 debatable. It's not controversial. It's pretty clear having a
16 gun in the home when you're depressed and have made suicide
17 attempts in the past, it's a terrible thing and when you're
18 separated and there's a history of domestic violence and a
19 victim is saying that your wife is saying that you're aggressive
20 and have anger problems, a firearm is a terrible idea in a home.
21 **Q.** Obviously victims or people who are ultimately victims
22 of domestic homicides may stay in relationships for a whole

1 variety of reasons and, in our work, obviously, we see it
2 regularly where there are acts of domestic violence where a
3 victim may leave, may come back, may not leave. There are
4 challenges, obviously, to recognizing that they're a victim of
5 domestic violence and knowing how to respond and whether leaving
6 is something that's feasible or not.
7 You have a slide, Major Decisions in Leaving an Abusive
8 Relationship, which is the next one. You say leaving can be
9 very difficult, a process. I think you've said this earlier, a
10 process not an event. What do you mean by that and what are
11 some of the barriers to individuals leaving domestic
12 relationships where there is violence?
13 **(12:40)**
14 **A.** When I talk about leaving being a process, it means
15 that somebody starts to think about leaving the relationship and
16 it may take time and courage. They may not want to leave until
17 they're sure, you know, they can be safe. You know, obviously,
18 victims may recognize that separation may trigger more violence.
19 So they may decide that staying in the relationship is safer
20 than leaving because they're not sure, you know, what's going to
21 happen, you know, when they leave for good. So there may be
22 multiple separations, trial separations, before there's a final

1 separation. So even though somebody ... I know in divorce
2 proceedings, you know, that somebody may say, you know, they
3 separated on, you know, July 3rd, you know, 2020. The reality
4 is there was probably a two-year process leading up to that
5 final separation.
6 Victims stay in an abusive relationship out of fear. You
7 know, they're afraid to stay but they're also afraid to leave.
8 Again, victims continue to love the perpetrator so, you know,
9 when you marry somebody and you love them until death do you
10 part, whatever the vows you made, marriage is a commitment, you
11 love them, and you might feel quite conflicted about leaving and
12 giving up on the relationship. You hope the perpetrator will
13 change. You hope he gets help. He may say, I'm sorry, I'll get
14 help, I'll change, I'll stop doing this, I'll stop drinking,
15 I'll get a job, I won't, you know. So, in my view, from many
16 victims, you know, hope is a triumph over experience. You know,
17 you keep hoping he's going to change and sometimes he does but
18 often without a radical intervention in terms of being involved
19 in active counselling or being in a batterer intervention
20 program and taking responsibility, he may not change.
21 The victims are concerned about the children. You know,
22 their partner is still the children's father. They're worried

1 about if they leave, are they going to have to go to another
2 home, are they going to disrupt the children from school. How
3 are the children going to feel? They also worry if they leave,
4 the perpetrator may go to court and get alternate weekend visits
5 or get joint custody. You know, so some victims feel they can
6 manage the child's safety better when they stay in the home
7 because if they leave and there's regular contact without her
8 there, then they worry about the children's safety.
9 There may be lack of financial resources in terms of, you
10 know, employment, housing, legal advice. Lack of skills for,
11 not in this situation, but obviously lack of employment skills,
12 if victims are financially dependent on their partner, how are
13 they going to manage on their own, lack of housing, losing
14 custody. It's not uncommon for victims to finally go to
15 Family Court and say, you know, my life has been hell for the
16 last 10 years with domestic violence but they have no police
17 reports or physical evidence and then they might be accused of
18 making up lies and, in fact, maybe they're just trying to
19 alienate the children against the other parent. So there's,
20 obviously, those concerns.
21 Believing the perpetrator's promises to change. Access to
22 resources. And sometimes victims may distrust the system. And

1 by that, I mean, obviously, you know, we like to believe that
2 there's safety and support out there. Obviously, if you're, for
3 example, an Indigenous woman in an abusive relationship, you may
4 question whether you can trust the police, whether the police
5 will be sympathetic and supportive. I'm not saying they won't
6 be but, obviously, you know, if your parents went to a
7 residential school, you feel you've been a victim of racism all
8 your life, you know, there's a history of colonization and
9 oppression, you may not trust authority.
10 You may not believe in the justice system for a variety of
11 reasons. You may have had contact with the police before and it
12 wasn't a good response or you're not sure how they're going to
13 respond. So the trust in the system can happen or distrust can
14 happen in a variety of ways and people may stop reaching out
15 because they think it's going to make it worse or there's no
16 real help.
17 **Q.** In your report, I guess at page eight and nine, you
18 also discuss the issue of patterns of disclosure and perhaps the
19 misconception that if someone is a victim of domestic violence,
20 they will immediately reach out for help or will go to the
21 police but that's not always the case, is that correct?
22 **A.** Yes, most victims don't contact the police and don't

1 disclose. Many victims live, you know, with the violence and
2 they may talk to friends or family but they often suffer in
3 silence and try to decide how they manage. By the time a victim
4 does reach out to the police, it's an important step and they
5 usually reach out more at a point of desperation when the
6 violence is escalating and they're concerned about their
7 personal safety, concerned about their life or they're worried
8 about their children's safety.
9 So victims are reluctant. And I can't tell you the number
10 of times I've been in court testifying in criminal trials
11 dealing with a victim of domestic violence and I'm being cross-
12 examined and someone says to me, Well, Doctor, there was a
13 police station just two kilometers down the road, why didn't she
14 go to the police, you know, if it was that bad? And I have to
15 explain all the reasons why someone may be reluctant to disclose
16 and why disclosing may make it worse. So victims overall tend
17 to be reluctant and they tend to delay in disclosing the
18 violence. I've often been called to criminal trials where
19 there's a delayed disclosure or victims who have actually
20 recanted. Victims may call the police in a point of crisis and
21 by the time charges result and they have contact with the
22 Crown's office or Victim Services, they want to recant

1 everything they've said and say, Well, he's back, it's not that
2 bad, he's getting help, and I don't want to proceed.
3 So I've been in court trying to explain to the court about
4 why victims recant. I have said on occasion when I'm presenting
5 this work to Crown attorneys to me, you know, you shouldn't need
6 a PhD to explain recantation. You know, to me, you know, the
7 more interesting cases are victims who actually follow through
8 because that's more surprising given the delay in court, given,
9 you know, preliminary hearings and trials where victims feel
10 they're on trial. You know, it's sometimes harder to explain
11 why somebody actually follows through rather than why they
12 recant.
13 I think in Canada and the US at least 50 percent of all
14 domestic violence victims who've called the police, by the time
15 it comes to court, they've asked the Crown to withdraw the
16 charges and not proceed. So it's no longer surprising you no
17 longer need an expert to explain that. It's generally
18 understood, I think.
19 **Q.** It's something we see regularly in our work, I can
20 say.
21 **THE COURT:** If you can find an natural break in your
22 direct examination then we can break for lunch, just if you can

1 keep that in mind.

2 **MR. MURRAY:** I think now would be fine.

3 **THE COURT:** Now is a good time, all right.

4 Dr. Jaffe, this is about the time we would normally take
5 our lunch break. Mr. Murray says this is a good time to take a
6 pause in the evidence. So we're going to adjourn for probably
7 an hour. We're at quarter to 1 here. So we'll return at
8 quarter to 1, your time.

9 **DR. JAFFE:** Thank you, Your Honour, I'll be back then.
10 Thank you.

11 **THE COURT:** All right, thank you, Dr. Jaffe, I
12 appreciate it.

13 **COURT RECESSED (12:49 hrs.)**

14 **COURT RESUMED (13:48 hrs.)**

15 **THE COURT:** Mr. Murray?

16 **MR. MURRAY:** Thank you, Your Honour. Dr. Jaffe, before
17 we broke we were talking about patterns of disclosure in
18 relationships with domestic violence and the dynamics of abusive
19 relationships. I want to ask you some questions about domestic
20 homicides. Your report and your PowerPoint have some
21 interesting and, I guess, very troubling statistics. At page 10
22 of your report you say that domestic homicides account for about

1 one in eight homicides around the world. I wouldn't have
2 guessed necessarily it was that high, perhaps I should have, but
3 that's the number, one in eight are domestic homicides?
4 **A.** Yes.
5 **Q.** And you say that in Canada between 2010 and 2019 there
6 were 815 domestic homicides with women representing 79 percent
7 of all victims and over half of these homicides involve
8 vulnerable populations. If we could bring up perhaps Exhibit
9 344 and go to slide eight. Demographic characteristics, page
10 eight. Perhaps you could help us with some of the demographic
11 characteristics of victims of domestic homicide. You have some
12 slides here that give us some information on that?
13 **(13:50)**
14 **A.** Yes. So this is from our national study that Myrna
15 Dawson at Guelph and I led with multiple universities so we
16 looked at all the homicides between 2010 and 2019, so a ten-year
17 period, and there was over 800 and obviously this is just a
18 basic summary that 79 percent of the adult victims were women,
19 the average age was 41, and most accused were males, 86 percent
20 were males, and the average age was 41 for them as well. And
21 the next slide breaks down some of the issues in terms of
22 vulnerability of the population.

1 **Q.** So again, going back to the four general categories of
2 vulnerable populations: Indigenous, immigrant/refugee, rural,
3 remote and northern, and children, those four groups together,
4 those four vulnerable populations accounted for 439 or 54
5 percent of the homicide victims, do I understand that correctly?
6 **A.** Yes. So over half belonged to one of the vulnerable
7 populations we were studying and clearly it's broken down
8 briefly but the Indigenous population is obviously extreme in
9 terms of the percentage of victims compared to the actual
10 population of Indigenous people across the country. With
11 immigrant and refugee, they were a significant number but they
12 didn't represent more than we would have expected per capita but
13 they had issues that I'll come to in a moment in terms of being
14 able to reach out for support. A high number of individuals
15 living in rural, remote, northern communities and then of our
16 domestic homicide population, approximately one in 11 was a
17 child.
18 I also try to make the point in this slide that you can
19 belong to more than one category. I mean, you can be Indigenous
20 and obviously living in a rural, remote community so you can be
21 represented by multiple categories so there's obviously multiple
22 dimensions to individuals.

1 And then the next slide we broke down some of the key
2 factors when we looked at the level of risk that people were
3 facing. So this is based on reviewing cases, interviews,
4 talking to professionals who work in different regions and when
5 we try to capture where some of the risk factors that maybe go
6 beyond all the risk factors I talked about earlier so this is
7 looking at the context of people's lives.
8 For example, Indigenous women maybe not only suffer from
9 domestic violence but also suffer from the impacts of
10 colonization and inter-generational trauma within their families
11 and community. Individuals who are immigrants to the country
12 not only dealt with domestic violence but often dealt with pre-
13 migration trauma, they were leaving a war-torn country and post-
14 migration stress in terms of being able to access employment and
15 housing and some of the language and cultural barriers to
16 getting help. At the top, the rural, remote communities talked
17 about some of the challenges in terms of having more limited
18 privacy in rural communities, everybody knows your business, and
19 the police officer that responds to the call may be somebody who
20 plays on your husband's hockey team, using a very narrow
21 example, everybody knows everybody's business. And firearms,
22 which are a major concern within rural communities because guns

1 are present for hunting and other, you know, protecting property
2 and other rural cultural issues. And then children obviously
3 are dependent in terms of not being able to be independent
4 actors and, again, some of this depends on their age and stage
5 of development but, you know, children who are trapped within
6 homes where there's domestic violence, and they may, obviously
7 depend on their parents and they may also be ambivalent about
8 reporting anything because they're concerned about being taken
9 away from their parents. So obviously these are national
10 issues, they're not specific to Nova Scotia.
11 I think in the center we try to sort of pull together what
12 are common issues across all the vulnerable populations and the
13 summary there is a sense of isolation, having more limited
14 services or inadequate response to needs around domestic
15 violence, economic issues, and living in a community where the
16 norms may be more conducive of domestic violence, where domestic
17 violence is more common and is not seen as something that
18 requires an external response from police or community agencies.
19 So the best example, I think, is Indigenous populations
20 where you're dealing with multiple generations because of
21 residential schools where many children and adults in the
22 community are dealing with the aftermath of child abuse and

1 there's a lost generation that may not have learned a great deal
2 about parenting because they grew up in a residential facility.
3 So there's also problems within Indigenous families that are on
4 top of all the other historical trauma I've talked about. So
5 that's one where there's so much violence it's hard to know
6 what's worth reporting and if you do, can you trust the response
7 and if you do, what kind of help is there going to be.
8 **Q.** Right. And that hesitancy to seek help through, say,
9 the police is a challenge for some communities?
10 **A.** Yeah, and this is obviously away from the focus of
11 this Fatality Inquiry but obviously in some Indigenous
12 communities they're very remote and the police would have to fly
13 in in order to provide assistance so not only there's a delayed
14 response in terms of policing, then there's obviously not ready
15 access to social services and mental health services that may be
16 required so it's another big challenge.
17 **Q.** Although you have identified Indigenous populations as
18 a particular vulnerable population, can you comment more
19 generally if what I may refer to as racialized communities are
20 sometimes more hesitant to access domestic violence services,
21 the services of police, or other domestic violence assistance?
22 **A.** Yes. Without generalizing, it's fair to say that

1 racialized communities may be more distrustful of the police.
2 They may not see the police as representing them or their
3 culture. They worry about racial stereotypes, you know, there
4 are many, many victims who are hesitant to call 911 because they
5 worry the police will make it worse.
6 I mean, often I think the most common reason women would
7 call the police is because they're worried about their safety,
8 they're worried about violence escalating and in racialized
9 communities they may worry that the police will come and make it
10 worse, that there may be an escalation of violence. The women,
11 the victims who call the police want the violence to stop, they
12 want help for their husband, but they're worried that either the
13 violence will escalate when the police respond or the remedies
14 will be too simplistic, it'll be jail but no help, will be
15 incarceration and some major legal problems and they may lose
16 their husband and the father for their children but there may
17 not be remedies offered in terms of the counseling that's
18 required.
19 **(14:00)**
20 **Q.** I had intended to ask you also, we skipped over it,
21 but slide seven or page seven of the PowerPoint is the annual
22 distribution of domestic homicide victims in Canada between 2010

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1 and 2019. The numbers appear to me to be up and down obviously
2 a little bit. Do you see any long-term trends in the statistics
3 in terms of the number of domestic homicides, any positive
4 progress that way?
5 **A.** I think there's progress if you look back over 30
6 years, you know, certainly the numbers are down but I would say
7 the last couple of years I don't have the numbers to share at
8 this point. The numbers have gone up because of COVID and so I
9 think there's, because isolation is already a problem, you know,
10 with COVID-19, the pandemic, you know, more victims are trapped
11 in homes with abusers and are less likely to get assistance so
12 we are seeing increases across North America but I couldn't give
13 you up-to-date numbers for Canada or obviously for Nova Scotia.
14 One of the, I'll just say this, one of the other challenges
15 is knowing how you define domestic homicides. It's generally
16 considered that domestic homicides are under counted, that is
17 although medical examiners and coroners across the country will
18 designate cases that are domestic homicide, there's often under
19 reporting due to dating relationships that may be short term,
20 they may not be defined as an intimate relationship but they are
21 and we don't do a very good job, you know, recording all the
22 deaths through third parties like, for example, the horrific

1 incident that's part of an upcoming provincial inquiry into the
2 April 2020 mass shootings. You know, there will be I'm sure
3 some discussion and debate about, you know, because that
4 incident reportedly, from public reports, began with an incident
5 of domestic violence. You know, to what extent are subsequent
6 deaths are considered domestic homicides including officers
7 responding after the fact, you know, responding to obviously
8 multiple reports of horrific things happening. So I mention
9 that because there's still no agreement about how we record and
10 count cases so even what I'm reporting here is an under count
11 but it is going up due to COVID on top of other issues.
12 **Q.** Okay. You say at page 11 of your report:
13 Domestic homicides appear to be the most
14 predictable and preventable of all
15 homicides. Friends, family, coworkers, and
16 professionals who had contact with the
17 victim and/or perpetrator often report
18 warning signs that had concerned them.
19 Often friends and family did not know what
20 to do or say. They may have been hesitant
21 to share their observations and worries.
22 Frontline professionals may have lacked

1 awareness or training about domestic
2 violence warning signs. Many people wish
3 they had taken action as speaking to the
4 victim or the perpetrator and encouraging
5 them to get help. Some wished they had
6 called the police or engaged the justice
7 system much earlier for protection.
8 So, and I know you've said this earlier in your evidence,
9 but it's your opinion that domestic homicides, of all homicides,
10 are the most predictable and preventable, Dr. Jaffe?
11 **A.** Yes, and that's not a controversial statement. I
12 think there'd be wide agreement with academics across the world
13 on that issue.
14 **Q.** There's a section of your report where you speak about
15 homicide/suicides and familicide. First of all, can you define
16 familicide?
17 **A.** Familicide refers to killing multiple family members
18 so generally it's multiple homicides and suicides. The Desmond
19 case would be a familicide.
20 **Q.** All right. And you say that between 25 and 30 percent
21 of domestic homicides are homicide/suicides. Is that statistic
22 across Canada or, sorry, that's internationally, is it?

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1 **A.** Yes, that'd be across Canada and the US. You'll see,
2 just one note to avoid any confusion later on, when we look at
3 our Ontario Domestic Violence Death Review Committee, the number
4 of homicide/suicides are higher at about, you know, 35 percent.
5 The reason they're higher is because that committee sees more
6 homicide/suicides because those cases come to us quicker because
7 we're not waiting for the criminal justice system and any
8 appeals to be completed so we review more homicide/suicides but
9 generally internationally it's between 25 and 30 percent.
10 **Q.** Right. I want to talk a moment about child homicides,
11 parents who kill their children. Can you give us, and this is
12 obviously one of the hardest parts of this for us to wrap our
13 minds around and to understand, can you give us a sense of how
14 prevalent it is and what the risk factors are for child homicide
15 and what maybe leads up to a child homicide in particular?
16 **A.** So my colleague, Myrna Dawson, has researched child
17 homicides in a variety of contexts and over a 50-year period she
18 reviewed there was 2,000 child homicides. Children are killed
19 in a variety of contexts, most often by parents. When we're
20 talking about child homicides in the context of domestic
21 violence, they're more often committed by fathers and usually
22 committed as an act of revenge, you know, for the mother ending

1 the relationship so that's the most common pattern. So
2 nationally we found that child homicides, in the context of
3 domestic violence, accounted for one in 11, actually nine
4 percent of all domestic homicides.
5 And again, children are killed in a variety of ways and
6 sometimes across Canada children are killed because they're in
7 the crossfire. They happen to be home, they may be protecting
8 one parent, you know, they're killed as part of a decision by
9 the perpetrator to kill everyone because there's no point in the
10 family continuing. Some perpetrators may spare children, some
11 perpetrators decide to kill everyone. In some cases we have
12 perpetrators across the country who decide to only kill the
13 children because they want to punish the abuse victim, the adult
14 victim, their former intimate partner, punish her for leaving
15 the relationship. And there's been a number of cases, you know,
16 on the national media over the last year that have profiled
17 these cases in much more detail but this is what we certainly
18 see regularly, both in our national research and also the
19 Ontario Domestic Violence Death Review Committee.
20 **Q.** Are there particular risk factors for child homicide
21 in domestic violence contexts perhaps beyond the risk factors
22 for domestic homicide generally?

1 **A.** The shorter answer is when you have the risk factors
2 for domestic homicide, you also have the risk factors for child
3 homicide. That is when a victim has a reasonable basis, in
4 fact, to be concerned about her safety, either herself or
5 through external risk assessment, the victim is in danger then
6 the children are also in danger. And that's, in our work in
7 Ontario, people are always surprised because I always say, I
8 usually say something like this is based on police interviews
9 after the fact, they usually say well I thought he might harm
10 himself, I never thought he'd kill his spouse or they say I
11 thought he might kill her but I never thought he would kill the
12 kids so this is something that's shocking but it's, from a
13 research perspective, it's not shocking. And what we often say,
14 especially when we're doing work with Family Court judges and
15 family lawyers, is basically say if the adult victim is in
16 danger, you have to be aware that the children may also be in
17 danger even though there's no history of physical or sexual
18 abuse. Living with domestic violence is a significant risk
19 factor.
20 **(14:10)**
21 **Q.** Right. And we've talked about the risk factors that
22 are used by the Death Review Committee and perhaps just to

1 follow along in your PowerPoint at page 11 and you've touched on
2 the purpose of the Domestic Violence Death Review Committee to
3 learn from domestic homicides, to prevent deaths in similar
4 circumstances in the future, to understand risk factors and
5 missed opportunities to intervene and make recommendations for
6 change to legislation, policies, practices, resources, public
7 education, and to provide training for service providers. That,
8 I guess, would be a fair encapsulation of generally the mandate
9 of the Death Review Committee is it, Dr. Jaffe?
10 **A.** Yes, I think that's, I think, a good summary in a
11 snapshot.
12 **Q.** Well, let's just follow along with that, perhaps if we
13 could go over to slide 16. I think you had made reference
14 earlier to the most common risk factors that are present in
15 domestic homicides. This is perhaps the most up-to-date list is
16 it or the most up-to-date ranking, if I could call it that, of
17 the risk factors?
18 **A.** Yes.
19 **Q.** So clearly, as you said earlier, the prior history of
20 domestic violence and actual or pending separation are the most
21 common. But obsessive behaviour, including stalking, depression
22 or other mental health problems, prior threats to commit suicide

1 or attempt to commit suicide, and an escalation of violence,
2 those are the next most common risk markers?
3 **A.** Yes.
4 **Q.** The next slide you said Who Knows What? Can you help
5 us out with what ... I assume these are people who may have been
6 privy to or seen risk factors? Where do these statistics come
7 from?
8 **A.** Yes. That's from our Death Review Committee in terms
9 of who has had first-hand knowledge about the abuse or violence
10 in the relationship. Either the victim or perpetrator disclosed
11 it, usually the victim, or they witnessed something first-hand.
12 And what this says is the family usually knows the most at 73
13 percent, you know, of our cases, a family member, sometimes more
14 than one family member, the victim may have disclosed to a
15 sister or a mother so 73 percent of the cases family knows. 65
16 percent friends, a victim may have told her best friend or a
17 perpetrator's friend has seen that happen, you know, at a
18 gathering, you know, at an outing has seen the behaviour.
19 Police have knowledge about these cases and 57 percent of the
20 cases there's been a police intervention. Lawyers, that's
21 either family or criminal lawyers have knowledge about, you
22 know, what's transpired. Coworkers in a third of the cases.

1 Medical professionals in 22 percent and the DV agency refers to
2 a specialized agency dealing with domestic violence, either in
3 Ontario we call them partner assault programs, also called
4 batterer intervention programs or a shelter for abuse victims or
5 an outreach service for abuse victims, 15 percent would have
6 some knowledge of the case prior to the homicide.
7 Actually one thing I should note, in Ontario and I know
8 these programs exist across your province as well, usually when
9 men are charged or convicted of domestic violence they're often
10 court ordered to go into a batterer intervention program, a
11 domestic violence perpetrator program, they're called different
12 things in different jurisdictions. Out of the last 500 cases
13 that I reviewed, either myself or my colleagues in Ontario, we
14 only had two cases where somebody actually completed a batterer
15 intervention program. And I mention that only that the problem
16 in my mind is not whether batterer intervention programs work or
17 don't work, the question is all too often we don't refer them to
18 specialized programs that could actually, you know, deal with
19 this very specific problem which in some cases is on top of
20 other problems the individual may have.
21 **Q.** And just so I understand what you said, a review of
22 500 cases, were they all involving men or ...

DR. PETER JAFFE, Direct Examination

1 **A.** It's men and women. So we have cases where women ...
2 in some cases women acted in self-defence and there's a history
3 of domestic violence but there was no prior treatment either for
4 her partner or herself around these issues, depending on the
5 facts of the case.
6 **Q.** Right.
7 **A.** So what we've seen is a failure of professionals and
8 social service and mental health to make referrals to more
9 specialized agencies who might deal with these issues.
10 **Q.** So of those 500 cases that you reviewed, and these are
11 500 cases involving homicides, only two of the perpetrators had
12 completed, fully completed a domestic violence program?
13 **A.** Yes.
14 **Q.** Why do you think that is? Mot being referred to not
15 being required to completed or ...
16 **A.** Some of it is lack of recognition of the problem.
17 They may have been getting help for other issues around
18 addictions or mental health but nobody actually labeled the
19 domestic violence as a problem. They chose not to get help on a
20 voluntary basis around domestic violence. In some cases they
21 were court ordered and they might have failed to comply. So
22 generally not being referred to the problem or referred to the

1 programs, the specialized programs, or if they were referred,
2 not following through and completing those programs. And that's
3 something consistent across North America that most abusers, you
4 know, deny and minimize their behaviour, deny and minimize the
5 impact of their behaviour on the victim or their children, and
6 they often may get help either at a point of crisis when they're
7 in court or they may get help if their wife threatens to leave
8 them if they don't get help but what we see in the research
9 often they go for help and they don't follow through, they don't
10 go to enough sessions to actually complete the program so
11 there's a lack of follow-up and then a lack of monitoring and
12 review of the need for treatment and compliance.
13 **THE COURT:** Mr. Murray, Dr. Jaffe, I just have a note
14 here and I understand that we have a small technical issue with
15 regard to the live stream and I think we might just have to take
16 a short break for a few minutes to get something synchronized so
17 that we can continue to live stream your evidence. So I'll ask
18 you maybe if you could just ... five minutes. Ian tells me it
19 will take him five minutes to make the correction or to make the
20 adjustment that's needed so we'll pause for five minutes and
21 then we'll be right back. Thank you.
22 **A.** Okay.

1 **COURT RECESSED (14:19 hrs.)**
2 **COURT RESUMED (14:29 hrs.)**
3 **THE COURT:** Thank you. Mr. Murray.
4 **MR. MURRAY:** Thank you, Your Honour.
5 Dr. Jaffe, we were talking about domestic homicide prior to
6 breaking and you actually prepared a number of slides. We've
7 talked about the Death Review Committees but you've prepared a
8 number of slides, which I think are helpful and perhaps we can
9 have a quick look at them, providing information about the Death
10 Review Committees in your PowerPoint. Slide 18 provides
11 information on, I guess it's fair to say, the four countries
12 that are kind of prevalent in this that we've gone to, the US,
13 UK, New Zealand, and Australia in their Death Review Committees?
14 **A.** Yes.
15 **Q.** All right. And the next one, I guess gives us the
16 years when various provinces have started their ... or no, I
17 guess that's most recent report from each of those provinces
18 that have those committees now.
19 **A.** Yes.
20 **Q.** Okay.
21 **A.** And I would also just indicate that they're all ...
22 Quebec just began in the last year.

1 **Q.** Right, okay.
2 **A.** And other provinces, for example, British Columbia,
3 has done two major Death Review Committees. They don't do it on
4 an annual basis but they do a number of cases. So they've done
5 two reports five years apart and so rather than ongoing annual
6 review. I'm not sure what they're doing in the future but in
7 the past they've done a number of cases altogether at one time.
8 **Q.** Right, okay. The next slide, I guess, categorizes
9 some of the general recommendations. And, again, we've talked
10 about this but the general types of or categories of
11 recommendations that Death Review Committees can make. I don't
12 know if there's anything you want to say to expand on that but
13 that's ...
14 **A.** Those are, if you try to categorize recommendations
15 across the country, those are some of the patterns of things
16 that are being recommended.
17 I might just say for the bottom two, they relate to
18 questions you've asked earlier but certainly increasing
19 recognition about children living with domestic violence and
20 their special needs. And the other question you asked me about
21 racialized group or marginalised groups, who may have unique
22 needs and need culturally appropriate and thoughtful

1 interventions that may not be what we would consider traditional
2 domestic violence interventions. And that sort of goes to the
3 whole theme about vulnerable populations and sort of the concept
4 of intersectionality and that is looking at the context of
5 individual's lives to make sure we're tailoring responses to
6 individuals' reality such as living in a rural remote community
7 or, you know, in this case, recognizing the unique needs of
8 African Nova Scotians.
9 **Q.** When you make recommendations then, I guess would it
10 be fair to say it's not uncommon increasingly for you to think
11 about culturally relevant recommendations for, I guess,
12 culturally relevant services for particular populations?
13 **A.** Yes, that's probably an increasing trend certainly
14 over the last 10 years that it's more and more it's not one size
15 fits all. We have a general sense of domestic homicides and
16 risk factors but we're seeing that we also have to have a lens
17 dealing, you know, with the particular individual and population
18 that we're dealing with. And I can give you lots of examples
19 but I think your question really captures it. We want to tailor
20 something specific to that population.
21 **Q.** And that's both for victim and perpetrators in,
22 obviously, more generally (inaudible - audio drop) domestic

1 violence?

2 **A.** Yes, there's unique needs and I could give you lots of
3 examples but certainly we're seeing lots of homicides or
4 homicides/suicides with older populations. So we are having to
5 make sure we're working with personal service workers and
6 doctors, more focused on older patients and geriatrics, to
7 recognize the risk with that population.

8 So, again, actually my colleagues and I co-edited a book on
9 preventing domestic homicides. In that book, we address
10 chapters specifically to some of the unique populations that we
11 have to think about in terms of the risks or the vulnerability
12 that they present.

13 **Q.** The next slide is entitled Common Goals But Domestic
14 Violence Death Review Committees Differ. So there are
15 differences, are there, in the way that the various Death Review
16 Committees approach their work? I think you have some listed
17 there.

18 **A.** Yes, so the first one, in Ontario, we review every
19 homicide as soon as it's cleared by the courts and we do that on
20 an ongoing basis. You know, with British Columbia, they do
21 reviews every five years. I'm not sure what their future plans
22 are. Some organizations work, you know, through the medical

1 examiner or coroners. Others are structured through a domestic
2 violence state-wide service, particularly in the US. Some
3 reviews have comprehensive information. I think in Ontario we
4 get access to everything I think we need to know about the
5 victim that's available from multiple service providers. Other
6 committees might have more limited access. Some monitor and
7 review recommendations. I think most don't. Some are well
8 funded. Some work on a shoestring budget, and some are
9 voluntary, getting together to review what's happened.
10 In some cases, particularly in the UK, there's a more
11 active role of survivors included in reviews. In our Committee,
12 we have survivors who are part of our review. And some share
13 information more broadly publicly and some have more limited
14 circulation of information with very little identifying
15 information. So those are some of the differences across
16 different review committees.
17 **Q.** The Ontario experience, you summarized the facts
18 without providing identifying information. Is that perhaps the
19 most common approach, to your knowledge?
20 **A.** Yes. Yes, I think that would be the most common, even
21 though it's fair to say that a lot of cases, especially in a
22 smaller community, given the facts, people close to the scene

1 can identify which case it is. So I think that's going to be a
2 challenge in Nova Scotia. Because even though you're going to
3 do anonymous reviews, or you're not going to publish names, at
4 least what I've seen in some of the potential regulations, I
5 think it's pretty hard not to identify the case. And, in some
6 cases, a lot of information is already public, if there's been a
7 criminal trial and evidence called and victim impact statements
8 at the time of sentencing, all the information, in fact, already
9 is pretty well public.

10 **Q.** Right. You've identified what you see as the positive
11 outcomes from the Death Review Committees, appreciating that you
12 said earlier you would like to be able to do more auditing of
13 the extent to which recommendations are accepted and acted upon.
14 But what are some of the positive outcomes that you see
15 potentially from the Death Review Committees?

16 **A.** Certainly see, you know, increasing public awareness.
17 I think our public education programs are good. Obviously, we
18 need broader circulation. Professional training has really been
19 enhanced. I think we've had a breakthrough in terms of domestic
20 violence in the workplace in terms of legislative change and
21 more a sense of collective responsibility. And I can't say
22 enough about how important that's been because it also touches

1 on public education because everyone in the workplace is getting
2 exposed to the information and it makes them think about these
3 issues and the potential dangers.
4 There's been a lot more with child protection in terms of
5 their training because exposure to domestic violence is one of
6 the most common calls for child protection in Ontario and it's
7 required increasing collaboration.
8 VAW stands for Violence Against Women Services. So in
9 Ontario, all the shelters, the advocacy services, services that
10 are focused on abuse victims, they're usually under the umbrella
11 of Violence Against Women Services that are more than just
12 shelters and there's much more collaboration.
13 And I would say there's been a tremendous change in the
14 police. I think police training has really been enhanced.
15 There's much more accountability. In Ontario, every police
16 service has a domestic violence coordinator. Every police
17 service has a specialist. And more and more, the senior officer
18 on the domestic violence team reviews all occurrences to make
19 sure, you know, the case has been handled well and there's
20 follow-up, if needed. So there's much more consistency. Risk
21 assessments are part of police standards and, you know, they
22 have been updated. So I think that's an area where there has

1 been tremendous progress.
2 **(14:40)**
3 **Q.** So risk assessments are now more commonly used among
4 all police agencies in Ontario, to your knowledge, or are you
5 able to say?
6 **A.** They should be 100 percent because if a police
7 officer goes to a scene and there's charges filed, they have to
8 do a risk assessment. If they don't, they're not following
9 police standards. So it's the only profession, other than Child
10 Protection, where a risk assessment is mandatory. It's part of
11 your job and, if you don't do it, you're not meeting your core
12 standards. I think the issue, without rehashing it, the
13 outstanding issue is the debate about doing risk assessments for
14 all domestic calls independent whether there's charges filed.
15 That's a thing that there's still ongoing debate and division
16 amongst police services.
17 **Q.** Okay. We're going to talk about risk assessments in a
18 moment but the last slide on the Death Review Committees are
19 some of the challenges faced by the Death Review Committees.
20 What do you see as some of the challenges going forward?
21 **A.** Well, some of the challenges are promoting and
22 publicizing the reports. I mean, generally speaking, without

1 stereotyping, most chief coroners and medical examiners aren't
2 really necessarily looking at social media and publicizing
3 reports and results. The approach generally is much more
4 passive. The report is available, it's online, and you hope
5 people can find it. You know, you'll make recommendations.
6 Obviously, people who are involved in a specific recommendation
7 will get a copy of the report but the challenge is making sure
8 the information gets out more broadly.
9 Another challenge is making sure one captures the voices of
10 surviving family members and friends of the victim. I think
11 family members and friends often have a lot to say and I don't
12 think we always do justice to capturing their perspective.
13 Funding is a problem. Obviously, having a Death Review
14 Committee takes proper funding to make sure you have staffing,
15 you know, for the reviews and to organize the information.
16 And to also call on experts. For example, in an Ontario
17 Death Review Committee, although we have core members, if we're
18 dealing with a complex issue, we may call in an expert to
19 educate us. For example, if we have issues around firearms, you
20 know, we usually get someone representing the office of the
21 chief firearms officer to explain some of the issues around the
22 license. Or there's issues around immigration law where we

1 might have a specialist to come in to talk about those issues so
2 the Committee can make an informed opinion because we don't want
3 to wade into an area we understand nothing about without making
4 sure we have the basic context.
5 And sometimes we might test a recommendation. We might
6 say, Here's an idea. Is that practical or realistic? And we
7 might get help in shaping a recommendation. So that's, I think
8 that's a challenge.
9 There's an issue, there's a debate about confidentiality,
10 particularly around homicide/suicides. Obviously, not in your
11 situation because of the Fatality Inquiry but we have police
12 services across Canada who, in the face of a homicide/suicide,
13 you know, there might be a short public release saying we found
14 two bodies and we're not looking for anyone and they never
15 indicate it's a family homicide and there's a lot of questions.
16 So there's some debate. There's conflicting viewpoints about
17 how much should be shared. Often family members want the story
18 told because they want to see other lives being saved. There
19 may even be conflict within the family as to what gets shared
20 but I think there's a big issue around confidentiality in
21 homicide/suicides. Because you, and just this is a small point,
22 but important, if you have such little information about a case

1 then nobody can relate to or understand how it might relate to
2 their circumstances. So you need enough facts to provide a
3 context and so there's some debate about how much is presented.
4 Again, there's a debate about how specific the
5 recommendations should be. And I think the number one issue is
6 implementing the recommendations because they're advisory in
7 nature, as we've talked about earlier this morning, you know,
8 who is responsible, do we track the recommendations, do we track
9 the responses, do we do an audit? So these are things that
10 we're now very much alive to in Ontario and I think you're going
11 to see a change in practice. That's my personal opinion. I
12 can't speak for the chief but I think there's going to be much
13 more accountability built into the recommendations, making sure
14 that if they're not implemented, there are good reasons. Again,
15 they're still advisory but we want to hear from people as to why
16 something can't be done or is impractical.
17 **Q.** Right, okay.
18 Dr. Jaffe, we've touched on or made reference to risk
19 assessment tools or instruments, and I know you've done work in
20 this area, you've studied in this area, and I wonder if we could
21 spend some time talking about what kind of domestic violence
22 risk assessment tools are available, how effective they are, and

1 so forth. And perhaps the next slide actually is helpful if we
2 go to it.
3 Can you give us a little general information to help us
4 understand in general categories how one predicts, well, you say
5 predicting re-assault or homicide. How you use tools, what the
6 various approaches are to attempting to predict risk. So you
7 have general categories to begin.
8 **A.** Right. So there's three approaches that are generally
9 considered in the field. One is the actuarial approach. And
10 what that means is really using research in the field to look at
11 what the risk factors are that are most common and then develop
12 a score. For example, one of those common ones is the ODARA
13 that police use which predicts the likelihood of a re-assault.
14 There's 13 items that a police officer checks off and then
15 there's some consideration that the higher the score the more
16 likely is that offender might reoffend. It's totally empirical.
17 It's based on what are the factors that we know through research
18 and the score sort of drives decision-making about designating
19 somebody as potentially high risk or likely to re-offend.
20 The second approach is structured professional judgement
21 and that uses a bit of the actuarial approach. That is, they
22 have risk factors that have developed from the research. What's

1 different is that there's some flexibility to put those factors
2 together and then end up not only with a sense of risk but also
3 use those factors to derive safety planning for the victim and
4 risk management strategies for the perpetrator. For example, if
5 addictions or mental health are an issue, to make sure, you
6 know, those issues, there's an intervention, there's appropriate
7 treatment. If, for example, access to guns is an issue, to make
8 sure everything is done, to make sure that there's no weapons in
9 the home or the perpetrator doesn't have access to weapons
10 through friends or family or other sources. So it combines both
11 the empirical approach but also allows the professional to use
12 their own judgement and also develop an action plan from the
13 tool.
14 And the last approach, the one that's most common, is
15 unstructured clinical decision-making. And what that means is
16 somebody based on their experience, based on, you know,
17 depending on their role, they've been a mental health
18 professional for 10 years or 20 years and they have a sense of
19 what is dangerous and they just use their gut instinct and
20 clinical wisdom. And it's the approach that's considered the
21 least reliable or valid because clinical judgement can just mean
22 making the same mistake over and over again over many years.

1 It's not really, it doesn't keep up with the research and what's
2 known about risk. So whenever anybody says, I have a hunch,
3 it's probably a bad way to start a sentence in risk assessment
4 and you're better off looking at a more structured approach.
5 **(14:50)**
6 **Q.** We canvassed this topic yesterday with Dr. Theriault,
7 more broadly, not specifically in the domestic violence context
8 but more in the suicide and homicide risk context more
9 generally, but I believe his evidence was that the unstructured
10 clinical decision-making approach is not really much better than
11 chance. Would you agree with that or put it somewhere on that
12 scale?
13 **A.** Yes, I think it's flipping a choice, it's flipping a
14 coin and I think it doesn't help in terms of prediction and
15 prevention.
16 **Q.** Even for a person working in the field who has a
17 significant amount of experience.
18 **A.** Yes, I think you still need the tool or structure. I
19 mean if you're just starting out it's part of what should be
20 ingrained in terms of how you approach these cases on a
21 structured basis. You know, if you're an aging professional,
22 like myself, your memory may go. You may try to remember

1 certain risk factors but, having a guide beside you, you know,
2 is critical to make sure you're covering certain issues and
3 you're basing it on what current literature is and you're also
4 keeping up to date on those issues. Because tools change. It's
5 just like other aspects, other fields, like medicine, you know,
6 the tools we use today aren't what we were using 10 years ago or
7 20 years ago. So the tools what we're using in this field are
8 going to be updated where new items are added and new research
9 is coming out that may direct us one way or the other.
10 **Q.** Just so you can help me understand, the structured
11 professional judgement approach, which is it fair to say that
12 may be perceived as the best of the three presently, or is that
13 fair?
14 **A.** That would be my preference. If I'm looking at all
15 three, that would be the one, I think, that's most
16 comprehensive. I think the danger in the pure actuarial
17 approach is that people could just make checkmarks and then add
18 the numbers and think they have an answer but the checkmarks
19 should be just the beginning of a process for a much more in-
20 depth analysis. So I certainly prefer the structured
21 professional judgement.
22 **Q.** You said, though, that with that, with the structured

1 professional judgement approach, there's still an empirical
2 basis for it. There are, you know, risk factors that have been
3 shown to be significant. But you said there's some flexibility
4 in the way those are approached or used, I guess, by the
5 professional.
6 **A.** Yes. For example, I'll just take an example from some
7 of our earlier discussion. Let's say you're dealing with a new
8 immigrant in the country and there's lots of risk factors but
9 you realize that part of the risk may be trauma in terms of
10 having immigrated to Canada from a war-torn country. So there's
11 trauma. They might have been involved in the military in their
12 home country. Or, as a matter of fact, they may not have been
13 involved in military but they distrust the police and government
14 based on their country of origin. They also may be having post-
15 migration stress, difficulty finding a job. You know, they
16 might have had an education in their home country that's not
17 recognized in Canada. So those are the kind of issues that they
18 may not be formal risk factors but you would certainly add that
19 as to one of the important dimensions and understanding the risk
20 and the issues that have to be addressed in terms of potential,
21 you know, risk management. So it allows you to deal with some
22 of the other factors that may not be part of your, you know, the

1 identified risk factors but they're important, provides broader
2 context, and it also leads you to better decision-making about
3 safety planning and risk management.
4 **Q.** Right, okay. And so if you're using the structured
5 professional judgement approach, you may still begin with one of
6 the, I guess, empirical tools but expand on it.
7 **A.** Yes, there are probably two dozen tools that are in
8 use across North America. You know, some are longer, some are
9 shorter. I would say there's probably 80 to 85 percent overlap
10 that the things you'd find in one tool you'll find in another
11 tool but you might find more items. So all the things that you
12 would find in an actuarial tool, you would find in the
13 structured professional judgement. Like it still starts with
14 the same risk factors. So the risk factors don't change. The
15 amount of information. There might be more detailed information
16 in the professional judgement because you're not only putting a
17 checkmark but you're indicating your source of information. In
18 the professional judgement, you're looking at multiple sources.
19 Actually, one of the important considerations with any
20 tool, you're thinking about how much time and training does
21 somebody have. So, for example, with police, police do a lot of
22 training, but I'll generalize when I say this, but police hate

1 writing a lot of reports, detailed reports, there's too much
2 paperwork, most officers will tell you, and the ODARA, which is
3 used most commonly, has 13 items which is manageable because
4 it's not seen as excessive, it's do-able, and it's helpful, and
5 there's some research on it.
6 Having said that, if you're, for example, a clinical
7 psychologist, a psychiatrist, and you have more time, you're not
8 just doing an assessment at the point of the crisis or police
9 call, if you're seeing somebody in a hospital or you're seeing
10 somebody where you have hours and you have multiple sources of
11 information potentially from the victim, from family members,
12 from records from third parties, then you can do a much more
13 comprehensive analysis.
14 So, again, just for sake of simplicity, just think about
15 how much time you have as a police officer. I have a brother-
16 in-law who is a police officer in a neighbouring community and
17 he says the average domestic will now take, you know, two to
18 four hours with separate interviews for the victim and
19 perpetrator and it's fairly comprehensive.
20 On the other hand, if you're a clinical psychologist or a
21 psychiatrist and you're being asked to offer an opinion for a
22 dangerous offender hearing, you know, or looking at the

1 likelihood of reoffending, you're going to have days and weeks
2 or months to prepare a report for court and then you've going to
3 have multiple sources of information. Maybe that's a simple way
4 to describe it. It depends who you are, your profession, how
5 much time you have, and the sources of information you have.
6 **Q.** And, of course, along that spectrum there would be a
7 whole variety of other professionals, domestic violence
8 counsellors, shelters, other medical professionals seeing
9 someone perhaps in an outpatient contact. The list would be
10 quite extensive, I suppose.
11 **A.** Yes.
12 **Q.** And they all have different imperatives and different
13 timeframes for them to do their assessments.
14 **A.** Yes, and two other points on that. One is, one point
15 is that there is some work being done, more in the US than in
16 Canada, looking at, you know, can we agree on a common tool with
17 a major item. So there's something called the Maryland
18 Lethality Checklist which has the top seven items from the
19 danger assessment that we'll be talking about shortly. And the
20 researchers there are trying to say why don't we all get
21 together and at least have seven common items. So whether
22 you're working in a shelter or a police department or Victim

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1 Services, or a clergy member, why don't we in our community
2 agree on these common seven items and why don't we all start
3 with that and then we can go to our individual variations, just
4 so we have a common language across different sectors. I can
5 send you a reference for that but that's one thing that's
6 happening.
7 The other thing that's happening with risk assessment that
8 sometimes people decide that they're not really comfortable
9 doing risk assessment and they'd rather wait for a specialist to
10 be involved. And I find that, for example, with family lawyers.
11 Family lawyers say, I think I know enough to do a screening. I
12 know enough, I want to have some basic questions to know if
13 there's a history of domestic violence and if there's a power
14 imbalance between the husband and wife, but I'm not going to do
15 a formal risk assessment. So I want to screen enough to be able
16 then to ask for a court-ordered, you know, custody evaluation or
17 a specialized assessment if I'm concerned about risk and risk to
18 the children. So that's another important discussion in the
19 field is at what point does somebody know enough to do screening
20 and at what point do we expect somebody in that organization to
21 actually do a more comprehensive risk assessment.
22 **(15:00)**

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1 **Q.** Out of curiosity, have they agreed on the seven
2 factors for the Maryland tool or is that still a work in
3 progress?
4 **A.** They've agreed and they're researching it. There's an
5 empirical study going on, and I can forward that. They'll be
6 the top seven that we have. There will be a lot of overlap. I
7 think the thing that's different in the US, with any US
8 research, access to firearms is always near the top of the list.
9 It's usually, you know, number three or four just because of the
10 more ready access to firearms in the US compared to Canada.
11 So with the US and Canada, we have the same rates of
12 domestic violence if you're counting punches, slaps, individuals
13 living with psychological and physical or sexual abuse. We have
14 comparable rates of violence. They have a much higher rate of
15 homicide. Their rate of homicide is much higher because of
16 access to firearms being much more common. So where we might
17 have 70 or 80 cases a year they have well over 2000 a year. So
18 their rates are double what they should be just based on the
19 population alone.
20 **Q.** So you had referenced earlier in your testimony the
21 danger assessment that was created out of the work of Dr.
22 Campbell. Is that one of the first risk assessments or danger

1 assessments?

2 **A.** Yes, it's one of the first and one of the most common
3 and again, dedicated to the issue of domestic violence.
4 Obviously, there's other risk assessments more generally within
5 forensic psychiatry and psychology looking at more general and
6 criminal behaviour and risk of re-offending that Dr. Theriault
7 likely talked about.

8 But the first specific tool for domestic violence, domestic
9 homicide was a danger assessment, and this tool, as I indicated
10 in my report, this tool was based on a study looking at major US
11 cities. They were collecting data on homicide, domestic
12 homicide victims, and also collecting a comparison group of
13 domestic violence cases without a homicide.

14 And the research found a number of factors that were more
15 likely to be associated with the homicides. So these factors
16 were put together and they form this tool, which is the danger
17 assessment.

18 **Q.** And the danger assessment is still used widely, is it,
19 today?

20 **A.** Yes, you'd find it used commonly in shelters for abuse
21 victims. I still use it in my clinical assessments. Sometimes
22 I'm asked to do assessments after the fact sometimes trying to

1 make sense of victim behaviour as to what extent they were at
2 risk, and I might use it and go back in time as to, you know,
3 what the situation was for that victim at a certain point in
4 time in terms of the risk factors that were present. So it's
5 still commonly used.
6 And the way it's developed as you can see whereas the
7 police sometimes depend on information about the perpetrator
8 that they may have access to in terms of prior criminal history,
9 this tends to be used with individuals interviewing victims. So
10 that's why it's commonly used in shelters.
11 And it's also more than just a checklist because you're
12 also engaging somebody in an interview as to the history of
13 abuse and the worst incident that happened and so that's also
14 part of a longer, more in-depth interview.
15 **Q.** All right. And so I understand, too, the ODARA, for
16 example, the instrument that's used by the police here in Nova
17 Scotia, which we're familiar with, is an instrument that's
18 designed to predict risk but risk of recidivism. Am I correct
19 about that, about re-offending?
20 **A.** Yes.
21 **Q.** Okay. Not all ...
22 **A.** That was ...

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1 **Q.** Go ahead.
2 **A.** I was going to say yes, the original research was on
3 re-assault.
4 **Q.** Okay. Whereas some of these instruments are just risk
5 of violence, period?
6 **A.** This is risk of homicides.
7 **Q.** Risk of homicide.
8 **A.** So the ODARA ... sorry, the danger assessment. Their
9 norm group are people who are killed. So this is, you know,
10 what factors are associated with homicide compared to domestic
11 violence, no homicide.
12 **Q.** Okay. Got you. All right. And the danger assessment
13 to your knowledge, because it's been around a while, has it been
14 modified as the literature changes or as our knowledge of it
15 changes?
16 **A.** Yes. I think there ... additional items have been
17 added. I can't recall which items are new but as the research
18 comes out items have been added and it's been empirically
19 tested. So it's based on initial research study, but it also
20 continues to be tested empirically looking at different
21 populations.
22 **Q.** You've also included another instrument in the

1 PowerPoint, the B-SAFER risk assessment, Brief Spousal Assault
2 Form For the Evaluation of Risk? Why have you included this
3 one?
4 **A.** This one is more of the structured interview. So in
5 this one you're looking at ... there's a lot of overlap with the
6 risk factors that we just saw in the danger assessment and the
7 risk factors that you saw in the summary of our Ontario Death
8 Review Committee.
9 What's different here is that you take those factors and
10 then you actually identify strategies, and I just took an image
11 in the slide of the actual tool and, for example, risk
12 management, you know, given the problems that are identified, or
13 the risk, what's happening in terms of monitoring the
14 perpetrator, you know, treatment intervention for the
15 perpetrator, supervision.
16 So it reminds the person who is doing this inventory to
17 think about not just the problem but also what are the potential
18 solutions to reduce risk? Because a very important point that
19 seems obvious but it isn't, that risk assessment is never an end
20 in itself, you know? You don't do risk assessment and tell
21 somebody they're in danger. Risk assessment has to lead to
22 safety planning and risk management.

1 So risk assessment has to lead somewhere, and the nice
2 thing about the B-SAFER, it reminds the professional involved to
3 think about what they do with that information and what are the
4 remedies that are going to be required and what's being
5 recommended to the individual, to their family or potentially to
6 the Court in terms of supervision and monitoring.
7 Also as you can see, it also has safety planning, what
8 steps could be taken to enhance the security of the victim.
9 Like for example, I have cases, I referred to this earlier in
10 terms of the workplace where somebody, you know, has left an
11 abusive relationship, they're still in danger for a number of
12 reasons, a number of risk factors, and in terms of victim safety
13 planning they may be told not to go to work.
14 So their workplace may be told that they're too much at
15 risk, both themselves and possibly coworkers, to go to the
16 workplace every day for a certain period of time and they either
17 have to work from home or work in another location. Just taking
18 that as a concrete example of safety planning.
19 **Q.** So in that sense, the B-SAFER tool almost guides the
20 professional into the structured professional judgment category,
21 I guess, by requiring a bit of exploration and expansion on just
22 the risk factors?

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1 **A.** Yes, and again, you have to be reminded even of ...
2 you know, and again, you know, we all think we can remember
3 things but, you know, more and more, you know, of everything I
4 do, I have a checklist of things I have to remember to do in
5 terms of issues, you know, I need a guide. I can't just
6 interview from memory and that's more than just aging. I think
7 it's hard for most people to integrate that information.
8 I know, for example, in the US this is an example that
9 might interest Justice Zimmer that I work with judges in
10 criminal and family courts that actually have a laminated sheet
11 on the Bench of risk factors they should be aware of. Because,
12 for example, in Family Court now across Canada I think 80
13 percent of litigants are self-represented. You know, so judges
14 aren't necessarily hearing from brilliant lawyers making the
15 best argument on behalf of each parent.
16 And they may, more and more, you know, the judges now
17 become a crisis counsellor and the judge is in the middle of
18 having to do their own risk assessment. And it's not uncommon
19 for some US judges to actually have laminated sheets on the
20 Bench to help guide them.
21 **(15:10)**
22 **Q.** Dr. Theriault yesterday made reference to the VRAG and

1 the DVRAG, the Violence Risk Assessment Guide and Domestic
2 Violence Risk Assessment Guide. I believe I'm hopefully using
3 the terms correctly. Are you familiar with those instruments?
4 **A.** Yes.
5 **Q.** Okay.
6 **A.** Actually, I'm not sure I can ask you this question,
7 but people often ask me what they should use.
8 **Q.** Well, that's where I was going, yeah.
9 **A.** And I would say just ... okay. I usually say just use
10 something. You know, use something that's got a body of
11 literature behind it. Like I'm never in the business of trying
12 to promote ... when people ask me what are my favourites, I'll
13 tell them what my favourites are in different contexts.
14 But ultimately if someone can't decide I say just make sure
15 you use something and make sure whatever you're using you can
16 find in the academic literature that somebody has done, someone
17 else has the reliability and validity of the tool, and also that
18 it's appropriate for your setting with the time and information
19 you have.
20 **Q.** Okay. Fair enough. When you said there a number of
21 instruments available, or a number of tools available and used
22 across Canada, I think you said somewhere around 20 maybe?

1 Something like that. Is that ...

2 **A.** Yes, at least and we did a survey and we found that

3 probably in our study about ten tools were the most common and

4 accounted for, you know, for 80 to 90 percent of the tools that

5 people were using. Some people also do a homemade tool. They

6 develop their own. They use an existing tool and they add to

7 it. So that's the other thing that we heard in our research.

8 **Q.** Is that through the Canadian Domestic Homicide

9 initiative that you did that research?

10 **A.** Yes, we actually published a study on sort of the most

11 common tools that people are using. Certainly, ODARA. The

12 ODARA and the danger assessment and the B-SAFER were at top of

13 the list.

14 **Q.** Okay. I had that document, and I don't think I marked

15 it. But I did mark an earlier document which is Exhibit 340,

16 the Inventory of Spousal Violence Risk Assessment Tools Used in

17 Canada. It's a bit older, updated in 2013, but you're familiar

18 with this document?

19 **EXHIBIT P-000340 - INVENTORY OF SPOUSAL VIOLENCE RISK ASSESSMENT**

20 **TOOLS USED IN CANADA**

21 **A.** Yes.

22 **Q.** And I just note at page ... well, if you go to the

1 table of contents, actually, the two pages list a large number
2 of risk assessment tools that are used across Canada. So
3 there's a fairly large number of them. You say, though, the
4 ODARA, the B-SAFER, and the danger assessment are the most
5 commonly used ones, though, across the country?
6 **A.** Yes.
7 **Q.** All right.
8 **A.** Certainly looking for domestic violence you might find
9 a, without a lengthy explanation, there are some people who work
10 in Corrections. So they're used to dealing with offenders who
11 are dangerous both in a family context but also in a more public
12 context and they use more broader correctional risk assessment
13 tools and rely on those. So that's also the other variation.
14 **Q.** Right. Okay. I wanted to ask you one other question.
15 If we could just touch on it briefly, because you've included it
16 in your report at page 16, and it relates to domestic violence,
17 domestic violence homicides, and the military. The prevalence
18 of, or the rates of domestic violence homicide are higher, I
19 take it, from your report amongst military personnel than the
20 general population, is that correct?
21 **A.** Yes, and that's obviously based more on US research.
22 I'm not sure if there's a Canadian study that looks at that, but

1 certainly in terms of the US studies and ...
2 **Q.** All right. From your review of the literature, is
3 that among active serving personnel or also veterans?
4 **A.** Both active serving and veterans, and obviously, you
5 know, as I indicate in that paragraph I mean there is ... when
6 we talk about the military, you know, we are, for the most part,
7 talking about a male-dominated institution and there's certainly
8 an underlying culture that's hostile to women, sexual harassment
9 and assault and those are the words of a retired Supreme Court
10 Justice. So it's not offering my personal opinion but
11 obviously, it's all over the literature and certainly captured
12 in Justice Deschamps' report about military culture per se.
13 And so there's considerable information written about the
14 military and domestic violence, certainly more research out of
15 the US. Studies also out of the UK talking about this being a
16 concern. And obviously, it extends to not only the culture
17 within the military but also potentially the aftermath of
18 soldiers returning home and trying to reintegrate back into
19 their families.
20 **Q.** And I think you make reference to this. But, you
21 know, serving in the military obviously can lead to situations
22 where veterans suffer from certain mental health conditions,

1 post-traumatic stress disorder obviously being one of them.
2 Does this contribute, from what you've read, to the risk of
3 homicide?
4 **A.** Yes, certainly, you know, post-traumatic stress
5 disorder. You know, it's a mental health condition that
6 provides, you know, additional risk, you know, for domestic
7 violence together with other factors.
8 And I want to be cautious here in that not everybody, you
9 know, it's a risk factor but it doesn't mean that everybody who
10 has post-traumatic stress disorder is involved in domestic
11 violence. So it increases the risk, you know, but it's usually
12 together with other factors in terms of being in a male-
13 dominated culture, having access to weapons or knowledge about
14 using weapons.
15 There's also research, I think I've summarized, that also
16 talks about some forms of trauma create greater risk in other
17 forms. So repeated exposure to violence. So having multiple
18 traumas from your service in the military. Also finding out
19 that a ... another important factor is hyperarousal, you know,
20 seeing a threat everywhere, having a more sensitive and
21 sometimes misleading appraisal of threat is another factor.
22 Blaming ... and again, perhaps since we're on this topic.

1 I mean there's lots of things written about with Cpl. Desmond's
2 file about his hypervigilance, about his wife being unfaithful,
3 his wife misusing the family funds, concern about him being
4 mistreated or misused by his wife in a variety of ways. So
5 there's a lot of that hypersensitivity which fits, I think, with
6 the literature not only about trauma but the nature of the
7 trauma and, certainly in his case, his preoccupation that his
8 wife is being unfaithful to him. So obviously that's a theme
9 that I know has been throughout this Fatality Inquiry.
10 **Q.** Right. Your Honour, I don't know what your plan is
11 for the afternoon, if you want to take a break.
12 **THE COURT:** I think we will.
13 Dr. Jaffe, we normally have a short afternoon break as
14 well. I suspect you've been to court often enough to know that.
15 So we'll try and break for 15 minutes, come back perhaps at 25
16 minutes to the hour. Thank you.
17 **A.** Thank you, Your Honour.
18 **COURT RECESSED (15:20 hrs.)**
19 **COURT RESUMED (15:40 hrs.)**
20 **THE COURT:** Mr. Murray?
21 **MR. MURRAY:** Thank you, Your Honour.
22 Dr. Jaffe, obviously one of the terms of reference that

1 we're dealing with here is whether the Desmond family had
2 adequate access to domestic violence intervention services and
3 when we asked you to prepare your opinion it was to help us
4 understand the topic of domestic violence broadly but also for
5 you to review materials and to give us your thoughts on the
6 issue of the family's interaction with various entities through
7 the lens of whether there was adequate attention given to the
8 issue of domestic violence.
9 And you've had an opportunity, I understand, to review a
10 number of documents that we provided you?
11 **A.** Yes.
12 **Q.** And those are included in Appendix A to your report.
13 Maybe it we could just bring up the report, I forget the number
14 of it again, but ... I guess 334.
15 **THE COURT:** 334 is the exhibit number.
16 **MR. MURRAY:** There's Appendix A. And obviously won't go
17 through all of these in detail but by category you reviewed
18 material from the RCMP and their various interactions with the
19 family along with the testimony of a number of RCMP officers.
20 Materials from St. Martha's Regional Hospital along with the
21 testimony of a number of doctors and other healthcare providers
22 at St. Martha's. Materials and the evidence of a number of

1 healthcare providers outside of St. Martha's in the community
2 with whom Lionel Desmond and, more broadly the family, but
3 primarily Lionel Desmond interacted. Materials from the
4 Canadian Armed Forces, including various psychiatric and
5 psychological progress reports prepared by those who treated him
6 in the CAF and the testimony of Dr. Joshi and Dr. Rogers.
7 Evidence and materials from the New Brunswick OSI Clinic along
8 with the testimony of Drs. Murgatroyd and Njoku. Information
9 from other healthcare providers specifically Dr. Smith in New
10 Brunswick. Materials from Ste. Anne's Hospital and the evidence
11 of the variety of healthcare professionals who treated him who
12 testified here. Evidence from Marie-Paule Doucette, his VAC
13 case worker and a number of materials that she had created. And
14 then the family and historical information. The audio
15 statements of a number of family and friends along with text
16 messages that were provided to you and the testimony of a number
17 of individuals in the family and friend structure that
18 testified. You were given information about the purchase of the
19 firearm, including the video from the gun shop. Evidence from
20 the Naomi Society, Nicole Mann. A number of timeline documents
21 that we had provided to you just kind of summarizing the
22 evidence. And the testimony from, most recently, Ms. MacDonald,

1 the Director of Family Services, and Ms. Langley, the Executive
2 Director of the Nova Scotia Advisory Council on the Status of
3 Women.
4 So you had an opportunity to review those various documents
5 and from those I take it you developed a sense of or what you
6 feel happened here and I'd like to get you to comment on that.
7 Perhaps we could just bring up Slide 28, or page 28, in Exhibit
8 344.
9 So having reviewed those materials, Mr. Jaffe, what were
10 some of the thoughts and some of the impressions you formed of
11 this tragedy?
12 **A.** Well, first and foremost, certainly an overwhelming
13 amount of information and it dates back many years. So
14 everything, I think, was extremely well documented and I think
15 the information I was provided was nothing short of thorough and
16 comprehensive, well organized. So it's hard to do justice to
17 all the information but I think, for the most part, when I was
18 reviewing the information, and what are on the slides are just,
19 I think, some central highlights and I want to preface my
20 comments by saying that I'm very conscious in doing death
21 reviews that it's never intended to be a blaming exercise, this
22 is a horrific tragedy and everyone suffers in the aftermath,

1 certainly family members, but also professionals who may feel
2 guilty and wish they had said or done something differently. So
3 I was trying to be careful in my review just to focus on some
4 central themes and, where possible, not identify a particular
5 professional or sector.
6 Having said that, I think my overarching theme was that
7 there were many warning signs related to domestic homicide that
8 weren't recognized that I think, in my opinion, if someone would
9 have sat down with Lionel Desmond or Shanna Desmond, as I
10 mentioned, you know, New Year's Day and reviewed everything they
11 had been through I think there would have been many red flags.
12 What struck me was the extent to which the terms "domestic
13 violence" or "abuse" were really rarely used. I found both, you
14 know, family members and professionals used a number of
15 euphemisms, you know, such as conflict, marital problems,
16 arguing, snapping, verbal altercations, interpersonal conflicts,
17 outburst, anger, but the terms "violence" or "abuse" weren't
18 used and, in my view, they would have been appropriate to use
19 going back many years.
20 I think my sense is that there was a risk of violence that
21 was escalating over time. There were many concerning incidents
22 and behaviours, some of them by themselves I think would set off

1 alarm bells, but taken as a pattern they would set off many
2 alarm bells in terms of the pattern of domestic violence over
3 the years.
4 I think one of the things that might have been misleading
5 to certainly to professionals is a focus on mental health
6 problems and post-traumatic stress disorder rather than domestic
7 violence. So I think the point I made in my report is we tend
8 to want to put things in one category or another and this is
9 very common. That either this is domestic violence or this is a
10 mental health problem.
11 And, in fact, I think in the Desmond matter there was two
12 very distinct albeit overlapping problems. There was
13 significant mental health concerns and also significant issues
14 around domestic violence. And I think sometimes it's hard to
15 put both of those things together because you want to say, Well,
16 there's just mental health problems and you sort of overlook the
17 violence or you acknowledge violence and minimize the mental
18 health but, in fact, both issues were throughout the file.
19 **Q.** Is that a phenomenon you've seen elsewhere, Dr. Jaffe,
20 that on occasion professionals will focus, for example, on
21 mental health issues and lose sight of the co-existence, I guess
22 I could say, of domestic violence problems?

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1 **A.** Yes, and it's very common. And certainly in this
2 situation, you know, Lionel Desmond suffered from, you know,
3 severe mental health problems. You know, the post-traumatic
4 stress disorder, you know, was severe, he had so many signs and
5 symptoms. There were multiple other problems that were
6 documented and also constant concern about him committing
7 suicide, concern about depression and him losing hope. So that
8 was so dominant I think there was a great deal of focus on
9 trying to keep him alive and functioning and I think what got
10 lost in that analysis was recognizing that, you know, that
11 Shanna and Aaliyah, you know, were also in danger. And
12 ultimately obviously his mother as well.
13 **(15:50)**
14 **Q.** Well, in recent years obviously, as a society we've
15 worked very hard to educate on the issue of mental illness and
16 mental health and to make efforts to remove some of the stigma
17 that's been attached to mental illness. And we're very cautious
18 not to make assumptions that individuals who may be suffering
19 from mental health problems are necessarily more likely to be
20 violent or commit acts of violence necessarily. Does that
21 sometimes get in the way of professionals being able to see the
22 risks, do you think? I put that out there for your comment.

1 **A.** Yes. No, I think that's a critical question. I do
2 think as mental health professionals we work so hard to try to
3 remove stigma from any mental health disorders. We want to
4 encourage people to come forward and seek help. We don't want
5 people labelled as, you know, strange or dangerous, so I think
6 the reality unfortunately, though, is that although most people
7 with mental health disorders, you know, are not dangerous or not
8 more violent, there's some diagnoses that may be associated, you
9 know, with increased risk of violence so it's important to also
10 recognize that and that might have been one of the factors in
11 this situation. The mental health problems were so overwhelming
12 that the impact of these mental health problems, the dangers
13 that were posed, were overlooked or minimized.
14 **Q.** Right. You've provided us with information on the
15 next slide that some of the common misconceptions that I guess
16 one sees generally and that you saw here, what are some of
17 those?
18 **A.** Well, the problem of the violence and abuse was never
19 named, I mean, no one actually sat down, you know, with either
20 Lionel Desmond or Shanna and talked about that both issues were
21 going on and there was an escalating concern.
22 There was no ... I found in the file with looking at the

1 mental health professionals' report certainly everyone was aware
2 of the suicidal behaviour or the symptoms, the suicide threats,
3 but the actual impact of those problems was really, I think,
4 ignored.
5 So obviously, you know, everyone was aware that the PTSD,
6 the depression posed a risk for suicide but there was no link
7 made between suicide and homicide. And, in fact, as I mentioned
8 earlier, suicide threats themselves is a form of domestic
9 violence and coercive control.
10 There's also in the interviews a focus on physical abuse,
11 you know, and whether, you know, whether Lionel Desmond, you
12 know, was physically abusive with his wife rather than
13 recognizing the multiple forms of domestic violence.
14 Throughout the file there's the expectation that somehow
15 Lionel Desmond is going to talk about how he's abusive. He does
16 ... one of the things I noted in my report that Lionel Desmond
17 was not in denial about the extent to which he needed help; he
18 was seeking help from multiple places. Clearly he was reaching
19 out up to the very end. He was reaching out for help. But the
20 expectation was somehow that he was going to be able to describe
21 everything that he was doing and the impact it was having.
22 There are parts in the file where he certainly discloses to

1 others that he thinks he's frightening his daughter, he's
2 frightening his wife. So there's some acknowledgement but it's
3 more limited.
4 And there's many missed opportunities to really engage
5 Shanna Desmond in terms of what she's dealing with. She's
6 trying to manage obviously a very difficult marriage, you know,
7 trying to manage, you know, mental health symptoms that are
8 very, very concerning. You know, there's text messages, there's
9 things posted on Facebook that are concerning. You know there's
10 elements of harassment, getting many text messages that are
11 unwanted and I think no one actually really engaged her in terms
12 of what she was dealing with.
13 You know up to the end she seemed to be trying to get help
14 for her husband. You know, even in one of the last hospital
15 visits she's there trying to seek help for her and in the report
16 there's even a misunderstanding of what's she's doing. And, in
17 fact, it's quite common for ... I mean victims want their
18 husband to stop doing what they're doing but they also want him
19 to get help. And I have a sense that even in one of her
20 hospital visits near the end, you know, she's there with
21 information that she's pulled together and she's able to provide
22 a chronology of what's been happening rather than on relying

1 him, because obviously, you know, it's clear that he's having
2 difficulties sequencing the history and all the events. There's
3 so much information to keep track of. But no time is spent
4 alone with her and asking her about what she's thinking and
5 feeling and the fears that she likely has up to the very end.
6 There's also no consideration of specialized domestic
7 violence programs. Like in Nova Scotia obviously there's
8 specialized services for victims and perpetrators of domestic
9 violence. He likely could have been engaged in a program which,
10 you know, would deal with some of the abuse and controlling
11 behaviour that he's involved with as he's becoming more and more
12 desperate. So there's no referral to those programs.
13 And even the referral ... even, I think, the RCMP certainly
14 gave Shanna information about Victim Services and I think Naomi
15 Society, and she did contact them at the very end but, in my
16 view, there should have been, you know, a more active
17 connection, you know. And I come back to my recommendation,
18 there should have been more active attempt to do a risk
19 assessment and share, you know, a third party perception as to
20 what the risks that were present and the fact that she needed a
21 lot more help and support with what she was dealing with. So I
22 think there were missed opportunities.

DR. PETER JAFFE, Direct Examination

1 And the last comment I put on this slide, I think Aaliyah
2 was overlooked. Her life was in danger. I mean, obviously,
3 hindsight is 20/20 and I know in doing any kind of fatality
4 inquiry we're always thought of being a Monday morning
5 quarterback in looking at this after the fact but, in my
6 opinion, this information would have been known before the fact.
7 There was enough concerning information about the risk to Shanna
8 and Aaliyah that something should have been considered about the
9 safety and the protection that she had.
10 And obviously she had, you know, she had a ... her mother
11 was caring and she had a grandmother, you know, an extended
12 family that were trying to be supportive, but this was more than
13 anyone could manage. I mean this was beyond what a family could
14 be expected to manage given the depth of the problems, so I'm
15 also certainly concerned about Aaliyah.
16 And actually, in my report, this might be coming up in a
17 future slide, you know, it seemed clear that Brenda Desmond was
18 worried about her daughter-in-law's safety and worried about her
19 granddaughter's safety. And I think in my report my opinion was
20 that she was there to provide safety and protection. And many
21 people felt that somehow she could reason with Lionel and she
22 could manage the situation as his mother. And I sense from the

1 things that were said in various interviews that she was there
2 to protect the family and she lost her life protecting the
3 family.
4 **(16:00)**
5 **Q.** I'd like to ask you a few questions about that. You
6 said now and previously in your testimony that it may have been
7 helpful and advantageous if someone could have taken Shanna
8 aside and talked to her about her fears and her experiences
9 alone. It's sometimes difficult, especially I would think in a
10 healthcare setting where a professional is providing treatment
11 to, for example, in this case Lionel Desmond as patient, to have
12 those conversations with a spouse who is not the patient
13 receiving the treatment. How does one, in that circumstance,
14 how does one do that?
15 **A.** Well, you have to talk to them alone. I mean, you
16 know, she's also somebody in need. You know, I think, you know,
17 there were a number of opportunities. You know, potentially
18 whether it's the RCMP or when she was in the hospital or even
19 during the discharge from Ste. Anne's there was a phone
20 conversation looking at, you know, Lionel Desmond going home. I
21 mean he's leaving a stabilizing unit without being stabilized.
22 He was going home with the same problems, in some ways even more

1 pronounced. Although there are progress in some areas,
2 obviously they were worried about him leaving the facility
3 early.
4 So there's certainly an opportunity to talk to Shanna alone
5 and say, You know, I know you're doing your very best for
6 Lionel, you're trying to support him and I'm wondering how
7 you're coping, how you're doing. I wonder what your concerns,
8 what your fears. She was certainly dropping hints throughout.
9 I mean there are certainly things that she was saying that would
10 have been openings, you know, for someone to ask more questions.
11 So, you know, she's a client too. And in my view,
12 obviously you have a primary patient, obviously Lionel Desmond
13 is the one who's diagnosed with the mental health disorder and
14 needs help, but obviously the family member, you know, also has
15 to be a concern or a client.
16 You know, the same way with the military. When he's being
17 discharged, when you're re-deploying somebody, you know, back to
18 civilian life he's going back to civilian life with risk
19 factors. You know, obviously the military completed an
20 assessment that showed he was very much at risk for not having
21 successful reintegration into the community. There were
22 multiple risk factors. So obviously there's things that are

1 going to have to be shared with Shanna and Shanna is going to
2 have to be engaged with his after care because under those
3 circumstances he's ending up back in a rural community with
4 certainly not enough supports in place and certainly not
5 supports who are well informed about this history to offer the
6 best they can offer.
7 **Q.** Right. You had commented on the fact that Shanna, on
8 occasion, was with Lionel at his medical appointments and was,
9 to some extent, his historian because he wasn't able to do that
10 and to some extent his advocate as well for healthcare and yet
11 she was also at risk.
12 Is there sometimes a misconception that if a spouse is, as
13 Shanna appeared, kind of the more organized of the two, the
14 advocate, that type of thing, that somehow they're not at risk?
15 **A.** Yes. So, I mean, I think we have stereotypes of who's
16 a victim and who isn't. You know, we often ... when I began
17 this work many years ago we thought, you know, victims of
18 domestic violence are poor or drunk, you know, they live on the
19 wrong side of the river, wrong side of the tracks, whatever
20 stereotypes we have in our communities. And the reality is that
21 the victims and perpetrators I've seen over the last 40 years
22 come from all walks of life, including professionals and school

1 principals, lawyers, nurses. So I think there's a tendency to,
2 you know, I think to just see her as well educated, well
3 informed and not really seeing her as trying to manage an
4 impossible situation and, in fact, being a victim herself.
5 And I was surprised by some of the testimony and some of
6 the notes because there didn't seem to be a lot of understanding
7 about the load she was carrying and the risks that were present,
8 and it's very common. If you ask most domestic violence victims
9 across Canada, you know, what the most important things for you,
10 you know, it's usually, I want the violence to end; I want to
11 get help for my husband; and I'm worried about my kids. So
12 that's usually at the top of the wish list and, therefore,
13 especially someone in her circumstance who's trained to be a
14 nurse and trained to be a caregiver for others, she's concerned
15 about her husband and what's happening. I think she has to be
16 engaged about what her needs are in the circumstance.
17 And certainly there's red flags all over the place, you
18 know, certainly in the last two years, they're accumulating at a
19 certainly an extreme level.
20 **Q.** You had said that there wasn't consideration given of
21 the possibility of a specialized domestic violence program to
22 complement Lionel Desmond's treatments. Would those and, you

1 know, speaking again as someone who works in the criminal
2 justice system, we see those programs initiated when someone is
3 charged criminally and convicted and perhaps on probation. It's
4 more of a challenge to have someone engage in a program like
5 that who's not subject to, for example, a probation order, am I
6 correct in that and what do we do?

7 **A.** Yes. Well, I think some of the programs ... and
8 again, I don't know enough about Nova Scotia and how your
9 programs are organized, but certainly you'd want opportunities
10 for people to attend on a voluntary basis, you know. That, you
11 know, things are getting out of hand. You know certainly the
12 jealousy, the harassment. There's a number of factors that
13 require some sort of intervention so you'd want those programs
14 available without having to have a criminal conviction.

15 **Q.** As you reviewed the materials, Dr. Jaffe, you
16 obviously did so with the lens of the various risk factors and
17 how many of them were present and I think as you went through
18 them you identified 20, I think, of the 41 that you use with the
19 Domestic Violence Review Committee that you found to be present
20 in the Desmond family?

21 **A.** Yes.

22 **Q.** It's a little difficult to read on this particular

1 slide but maybe we'll go through these with the table that's
2 there are the 20 that you identified I think as you went through
3 the materials?
4 **A.** Yes, so there ...
5 **Q.** Perhaps we can switch over to the report 334.
6 **THE COURT:** Sorry, Mr. Murray, which document do you
7 want?
8 **MR. MURRAY:** Dr. Jaffe's report and I'm looking at
9 Appendix B which should be on page 44.
10 **THE COURT:** Thank you.
11 **MR. MURRAY:** So in your report you went through the
12 various factors and pointed to where in the evidence you found a
13 basis for saying that those were present. And I assume this is
14 a similar kind of exercise that you have to do with the death
15 review committees. You have to point to actual evidence in the
16 materials that supports a finding that one of those risk factors
17 was present?
18 **A.** Yes.
19 **Q.** All right.
20 **A.** And in this situation I wasn't exhaustive for many of
21 these factors. There could have been multiple examples but I
22 just picked some of the examples.

DR. PETER JAFFE, **Direct Examination**

1 **Q.** Okay. And perhaps if we could go through some of
2 these. So in "Perpetrator History: Perpetrator, (that is
3 Lionel Desmond) was abused and/or witnessed domestic violence as
4 a child." And here you found a comment in a document prepared
5 by the CAF?
6 **A.** Yes. And obviously in this situation Lionel Desmond
7 reported, you know, a history of severe verbal and physical
8 abuse in childhood so it's reported, it's in the records. And
9 obviously I know that's one factor that's not consistent because
10 I think the reports from the family were inconsistent with that
11 finding in the psychiatric report.
12 **(16:10)**
13 **Q.** Right. So how do you deal with that? Like, for
14 example, I know the evidence of Cpl. Desmond's sister was that
15 of perhaps a happier childhood and the statement that was
16 recorded from Cpl. Desmond wasn't detailed. Does the existence
17 of that statement allow you to identify that as a risk factor
18 irrespective of other information that might run contrary to
19 that?
20 **A.** Yes. I mean, if it's in the official records
21 obviously he's ... I'm not ... in general, people don't report
22 severe verbal, physical abuse in childhood for no reason, that's

1 their experience, that there's memory. And obviously family
2 members, there may be things that family members that didn't
3 witness, it's also ... you know, I can't imagine how difficult
4 for this would be for family to go through this and obviously
5 talking about some of these things would be difficult.
6 So either they weren't witnessed or they're very hard to
7 talk about at this point. I can't say, not having done
8 obviously firsthand assessment, this is sort of after the fact
9 looking at the record as we do in our death review committee.
10 **Q.** Right. Obviously you have a number of supporting
11 pieces of information for an actual or pending separation.
12 There was a fair amount of suggestion that the couple was moving
13 toward a separation?
14 **A.** And it seemed more final at the end. Like obviously
15 they seemed more separated than together, sometimes by
16 circumstances in terms of living apart in terms of when Shanna
17 went to go back to school and then got a job and was in Nova
18 Scotia. But there seemed to be reports that there was multiple
19 separations.
20 And I would say that some of those you might find and I
21 would find in other files where there's a temporary separation
22 where things were getting out of control and he goes to live

1 alone or goes to live with another family member for a period of
2 time and then they're back together.
3 I think what's striking, and what I put in my report, there
4 seemed to be more serious talk about divorce at the end. There
5 was talk, comments about custody. And obviously at the very end
6 when Cpl. Desmond reaches out and changes from couple
7 counselling to individual counselling he obviously knows that
8 he's not going to be doing couples counselling, he's going to be
9 on his own. And Shanna is reaching out for information about
10 peace bonds and family law proceedings, so it seems to be headed
11 in a more final direction at the end.
12 **Q.** And as you've said earlier, actual or pending
13 separation is one of the most common risk factors for domestic
14 homicides.
15 **A.** Yes. And I don't ... and again, I'm speculating
16 obviously. In my report I was very clear obviously I'm coming
17 in after the fact so obviously I never had a chance to assess
18 Cpl. Desmond or Shanna Desmond or talk to family members, so
19 this is after the fact so I'm really speculating. And I'm
20 speculating based on what I've seen in patterns and other
21 situations similar to this. And my sense is that that certainly
22 Shanna Desmond was on the road to separation and divorce. And

1 she had been hanging in there as long as she could hoping that
2 her husband would get help or would change but things seemed to
3 be escalating in terms of the concerns that she had reported to
4 multiple people.
5 **Q.** Yeah, "Perpetrator unemployed". Obviously Cpl.
6 Desmond at the end was not employed any longer, no longer in the
7 Armed Forces and had no other employment at that time.
8 **A.** Yes, and that was ... you know, each of these are an
9 individual factor, but that's another very significant one. I
10 mean he took great pride in being in the military and leaving to
11 join the military. And he came back, you know, in the words of
12 many family members and mental health professionals, a broken
13 man with his life on a downward spiral. He went from feeling
14 valued, making a contribution to society, to not being able to
15 find a job or not find a satisfying job. So that I think that
16 was another big risk factor. That was a big stressor for him
17 not feeling that he was doing something useful.
18 **Q.** "Child custody and access dispute." That's, I guess,
19 part and parcel of the pending separation and there was some
20 references, as you say, to issues of what might happen to
21 Aaliyah if there was a separation.
22 **A.** Yes. I mean there are definitely clear notes about

1 things that he said about that ... you know, that he didn't ...
2 he was worried about the influence of Shanna and her family
3 raising Aaliyah and comments about custody fights. And
4 obviously Shanna was concerned about the safety of her daughter
5 and the care of her daughter as well.
6 **Q.** In the category of "Perpetrator Mental Health", you've
7 classified excessive alcohol and/or drug use by the perpetrator
8 as a risk factor that was present. It's, I guess, somewhat
9 unclear ... Cpl. Desmond struggled with some alcohol use in the
10 past, it appeared to be less so near the end, and obviously the
11 medical marijuana that he had been prescribed he was no longer
12 using that at the end. From your review, though, there was
13 enough indication of either or both of those in the preceding
14 year to indicate that this was a risk factor?
15 **A.** Yes. It's a judgment call because it's in the record
16 and there's reference to relapses, you know, and there's
17 reference to him struggling, you know, to stay sober. So
18 certainly it appeared less in the records closer to January
19 2017, but there was enough reference that I thought it was
20 important to include it.
21 **Q.** Right. In your list of factors you have depression
22 obviously, and my recollection the risk factors is that

1 depression obviously professionally diagnosed is a risk factor;
2 depression identified by friends and family is also a separate
3 risk factor. Obviously there was numerous diagnoses of major
4 depressive disorder for Cpl. Desmond by professionals. Did you
5 see this as something others identified as well or described in
6 his behaviour?

7 **A.** Yes. And, again, he had ... obviously in the record
8 there's different presentation. I mean obviously there's good
9 days and bad days that are described but the overwhelming
10 pattern is not only the trauma symptom but was feeling depressed
11 and hopeless. And going through multiple separations where
12 there's times when he's back together with Shanna and then
13 there's some crisis or incident and they're apart again and he
14 continues with the concern about her not being faithful to him.
15 So there's ongoing issues that he's talking about and feeling
16 very discouraged and depressed, so I think everybody indicated
17 that in one or another.

18 **Q.** Beyond the diagnosis of depression, there were a host
19 of other mental health issues, the most significant of which
20 obviously was the post-traumatic stress disorder, but other
21 diagnoses that various professionals either made or couldn't
22 rule out or speculated about. What did you make of the various

1 ... as you read through it the various diagnoses and the various
2 mental health conditions that Cpl. Desmond was struggling with?
3 **A.** I think it was dominated by depression and suicidal
4 ideation and all the PTSD symptoms. The other ones were often
5 mentioned in passing but they weren't there consistently so they
6 were concerning but I wouldn't make any specific findings.
7 At St. Martha's Hospital there's some reference to post-
8 traumatic brain disorder and throughout the file there's talk
9 about concussions. I'm not sure to the extent of which
10 concussions were ever, you know, formally diagnosed but there's
11 certainly reference to that and reference to him needing a
12 neuropsychological assessment.
13 **Q.** Right. Just on that point, he didn't ever have
14 obviously a neuropsychological assessment. Can you comment on
15 if a person is struggling with a brain injury how that can
16 interact with domestic violence?
17 **(16:20)**
18 **A.** It could be an additional factor, I mean it depends on
19 the nature of the brain injury. Certainly some injuries, you
20 know, related to, you know, temporal lobe may affect judgment
21 and decision-making. So it would depend on the nature of the
22 injury.

1 So certainly it would be a situation where if he had been
2 referred to me I would have been looking to a neuropsychologist
3 to do a full work-up to understand.
4 There was constant reference to his organizational skills
5 and memory which certainly were worrisome, but he needed a full
6 assessment in order, you know, to make those findings.
7 It's often hard to know because with PTSD given, you know,
8 the anger, the hyperarousal, there's so many other factors,
9 could interfere with his thinking and ability to organize his
10 thoughts in terms of talking to others. So you'd need to make a
11 differential diagnosis of to what extent is it one problem or
12 maybe there's two problems and they're interacting with each
13 other but they're certainly something that was worthy of further
14 investigation.
15 **Q.** You found ...
16 **A.** And that ... I was just going to say, worthy for
17 further because in this situation it's not random. It's not
18 like I think I might have a concussion, you know, I fell as a
19 child. He actually has fairly detailed descriptions of
20 injuries he suffered that would be associated with some sort of
21 head trauma and potential concussion. So there's actually a
22 history he's reporting that's for the ... it's not enough to

1 make the diagnosis of concussion but it's certainly worthy of
2 further investigation.
3 I think this is more an aside and it may not be related. I
4 have four sons and one of them got a concussion from being hit
5 ... he was in front of the net and he got hit by a puck as a
6 teenager and even as a psychologist knowing about concussions I
7 didn't see any immediate symptoms and I had to take him to a
8 specialist who went through a structured inventory and did a
9 thorough assessment to diagnose the concussion.
10 So even as a psychologist and a parent I was unable to
11 diagnose the concussion myself. I was worried about the injury
12 that could be associated but I had to go through the assessment
13 to have it confirmed and I think it was certainly needed in his
14 case.
15 **Q.** Right. Okay.
16 **THE COURT:** Mr. Murray, I'm just going to note that we
17 are coming towards the end of the day and if you find a spot
18 that you think it's convenient to pause until tomorrow morning.
19 I'll leave it to you to make that decision.
20 **MR. MURRAY:** I was going to continue to go through the
21 risk factors but, I mean, it's going to take a little bit of
22 time. Maybe it's appropriate to leave off here and pick up

1 tomorrow.

2 **THE COURT:** Okay. Because when I look at the appendix

3 and just to probably create a better flow, if we pause now and

4 return to it and deal with the appendix as a whole tomorrow

5 morning I think it'll, from my point of view, it will present a

6 little better. Be a little easier for everyone to follow, I

7 think.

8 So, Dr. Jaffe, we're going to close for the afternoon.

9 We'll pick up tomorrow where Mr. Murray left off on the appendix

10 and dealing with perhaps some of the mental health problems or

11 psychiatric problems and we'll just continue from that point

12 tomorrow. All right?

13 **A.** Thank you, Your Honour. We'll see you in the morning.

14 **THE COURT:** All right. Thank you very much for your

15 time then.

16 Counsel, we'll adjourn and we'll close down the record.

17 And maybe counsel if they can just give me a few minutes of your

18 time. Again, thank you.

19

20 **COURT CLOSED (16:24 hrs.)**

21

22

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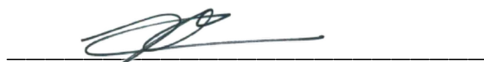

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