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 4, 2021

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1 **NOVEMBER 4, 2021**
2 **COURT OPENED (10:30 hrs.)**
3
4 **THE COURT:** Thank you. Good morning, Dr. Jaffe.
5 **DR. JAFFE:** Good morning, Your Honour.
6 **THE COURT:** Sorry for the delay. As I said the other
7 day, I think you've been in court often enough to understand
8 that there are many things that go on that often require special
9 attention that arise and alter our schedule but I hope it wasn't
10 inconvenient to you.
11 **DR. JAFFE:** No, Your Honour, I am here to serve the
12 Fatality Review and the Court.
13 **THE COURT:** Thank you, I appreciate that. Mr. Murray?
14
15 **DR. PETER JAFFE, still affirmed, testified:**
16
17 **DIRECT EXAMINATION (Cont'd.)**
18
19 **MR. MURRAY:** Good morning, Dr. Jaffe. When we left off
20 yesterday, I think we were looking at the appendix, Appendix B,
21 I believe, of your report and kind of reviewing some of the risk
22 factors that you had identified and the factual basis or how you

1 came to conclude that those particular risk factors were present
2 as you reviewed all of the materials. So if we could perhaps go
3 back to Exhibit 334 and to Appendix B, and I think we were on
4 page 46, if I'm correct.
5 **THE COURT:** Either partway down 45 or 46, yes.
6 **MR. MURRAY:** I think we had spoken about some of Cpl.
7 Desmond's other mental health problems at the bottom of 45 and
8 how those gave rise to a risk factor. I think on 46, obviously,
9 one of the risk factors, I think you said yesterday, and in your
10 work with the Ontario Domestic Violence Death Review Committee,
11 prior threats to commit suicide by the perpetrator is one of
12 the, I guess, most prevalent and most, and thus most concerning
13 perhaps risk factor for domestic homicide. Do I recall that
14 correctly, Doctor?
15 **A.** Yes, particularly ... so certainly putting depression
16 together with prior threats to commit suicide or actual attempts
17 is very significant.
18 **Q.** And, obviously, so that constitutes a risk factor,
19 separate and apart from that, an actual attempt at suicide, and
20 we did hear evidence and there was an entry in the records from
21 Ste. Anne's Hospital that one witness had recorded that Cpl.
22 Desmond had made reference to potentially making a suicide

1 attempt some five years earlier, although it was, obviously,
2 some time in the past, but the reference there would also have
3 constituted a risk factor separate and apart from threats to
4 commit suicide, is that correct?
5 **A.** Yes.
6 **Q.** Thank you. So you've identified some behaviour on the
7 part of Cpl. Desmond under the category of Perpetrator
8 Attitudes/ Harassment/Violence and you identified obsessive
9 behaviour displayed by Cpl. Desmond. What was the obsessive
10 behaviour that you saw that you felt would constitute that
11 particular risk factor?
12 **A.** One of the good examples would be the continuous
13 texting. There were reports about dozens and dozens of text
14 messages that he would have sent to Shanna that were, obviously,
15 unwanted and represented part of that obsession.
16 **Q.** Right. And, as we said yesterday, even if those texts
17 or those repeated communications on the part of the perpetrator
18 appeared on their face, and I used the word to be benign,
19 yesterday, you said they are anything but that. They are of
20 concern, is that correct?
21 **A.** Yes. Yes, they still should be taken seriously.
22 **Q.** You identified sexual jealousy and we've heard

1 evidence
2 of Cpl. Desmond not perhaps having full and frank delusions but
3 being very suspicious or paranoid about his wife having an
4 extramarital affair despite the fact that there was no evidence
5 of that. That would constitute sexual jealousy as a risk
6 factor, would it?
7 **A.** Yes, and it's certainly something that predominates in
8 the file. It's repeated dozens of times in terms of his
9 concerns that his wife may be seeing somebody else. There never
10 seems to be a rational basis. Actually, one comment I would
11 make, it doesn't really matter whether it's a delusion or
12 whether it's just regular jealousy that's not a delusion, it's a
13 serious factor and we've seen that repeatedly in the Ontario
14 Domestic Violence Death Review Committee. We've even had cases
15 with homicides that involve individuals with dementia where they
16 have total delusions that their wife is seeing another man or
17 other men and it still is given the same serious weight, whether
18 it's delusional or real, it's a concern.
19 **Q.** So it's what's in the mind of the perpetrator moreso
20 than what the reality is.
21 **A.** Yes.
22 **Q.** You've identified prior destruction or deprivation of

1 the victim's property and we did hear and there is in the
2 evidence some reference to Cpl. Desmond when he was upset,
3 breaking furniture or taking his frustration out on physical
4 objects in the family home. That would constitute destruction
5 or deprivation of the victim's property, would it, as a risk
6 factor, even if it's property that they both own together,
7 perhaps?
8 **A.** Yes.
9 **Q.** You've identified history of violence outside of the
10 family by the perpetrator as a risk factor and so this is any
11 kind of violence. It doesn't have to be domestic violence. Any
12 kind of violence by the perpetrator outside of the family, that
13 would constitute a risk factor. Do I understand that correctly?
14 **A.** Yes.
15 **Q.** And the family here, because the basis for it, you've
16 said assault against the father-in-law is reported by a CAF
17 psychiatrist, that's outside of the family unit being Cpl.
18 Desmond, his wife, and child.
19 **A.** Yes, it's external to the intimate relationship.
20 **Q.** Okay, all right. Obviously you've identified history
21 of domestic violence with the current partner as a risk factor
22 and you've identified a number of factual bases for that and, in

1 your evidence yesterday, you helped us understand how broadly
2 the term "domestic violence" should be defined and understood.
3 What were some of the acts of domestic violence that you
4 identified that were of concern to you?
5 **A.** Well, there are multiple but certainly in one text
6 exchange, Shanna claimed that Lionel was physically abusive.
7 There's lots of name calling which, you know, would be fitting
8 under emotional and psychological abuse. There's text messages
9 or testimony where he apologizes for putting his hands on her.
10 There's reference to anger management. This is my comment
11 yesterday where I think there's lots of indications of domestic
12 violence but they're described with euphemisms, such as anger
13 management. There's other points in the file, I think, where
14 Shanna is talking to a family physician, I'm forgetting his
15 name, the one who was involved in the marijuana, use of
16 marijuana treatment, and she indicates that he's being
17 aggressive.
18 **(10:40)**
19 **Q.** And you've also identified two incidents, one that
20 we've heard about where Lionel Desmond awoke from a dream, it
21 would appear, and was choking Shanna. And another piece of the
22 evidence from Kenny Greencorn where he indicated that Lionel

DR. PETER JAFFE, Direct Examination

1 Desmond had told him that he had a dream of cutting off Shanna's
2 head. Those, obviously the first incident involved physical
3 contact, albeit it appeared after having awakened. The other
4 was his discussion of a dream. That would fall into the
5 category of domestic violence or within the definition of
6 domestic violence, would it?
7 **A.** It would certainly be concerning to a victim. I want
8 you to picture, you know, the average Canadian woman hearing
9 from her partner that he's had dreams of cutting her head off or
10 variations of that theme. It would certainly be concerning and
11 alarming. So, again, any one of these issues in isolation may
12 not be given a lot of meaning but, in their totality, in the
13 context of the separation, the history, the other concerns it
14 would be very worrisome and it would certainly concern a victim.
15 **Q.** Right, okay. You've identified, and this would have
16 been in the text messages, that there was, even if it was not
17 directly something that Cpl. Desmond said, a reference to his
18 having said something, this being, "He wants to kill us all."
19 "Let her know I got eyes on a .22 Magnum." So two different
20 passages in the text messages. One, it would appear from Cpl.
21 Desmond, one from him through another person. Those both would
22 constitute, in your view, potentially threats to kill the

1 victim, which would be risk factors in and of themselves.
2 **A.** Yes, they would be very serious threats and, again,
3 just a reminder that I mean context is everything. You know, if
4 your husband was an accountant, you know, he had never been
5 involved in any kind of violence, he didn't own any firearms, he
6 wasn't into hunting, that would be concerning in itself. You
7 know, if your husband is a member of the military, or police,
8 and has intimate knowledge of firearms and, in this case, has
9 been to war, it would be extremely frightening to hear something
10 like that. So I think the overall context also, I think,
11 magnifies some of these threats.
12 **Q.** So as one assesses the risk factors as we go through
13 these, I take it from your evidence that the context in which
14 they were found is a factor to bear in mind, is it?
15 **A.** Yes, it certainly magnifies the risk and you would be
16 taking that very, very seriously.
17 **Q.** You identified as a risk factor a prior threat with a
18 weapon and, again, this can be a prior threat to any person, it
19 doesn't have to be the intimate relationship or within the
20 intimate relationship.
21 **A.** I think it's ... I'd have to go back and review but I
22 think it should refer to the intimate relationship. So I think

1 when I wrote this, I noted the father-in-law but I think it
2 should be directed towards the victim. So I think this may have
3 been ... I may have been over-inclusive in terms of having noted
4 that from the file.
5 **Q.** Okay, fair enough.
6 You've identified the perpetrator controlling most or all
7 of the victim's daily activities and, obviously, one of the
8 sources of tension in the relationship and one of the areas that
9 Cpl. Desmond often focused on was their finances and whether
10 they were being properly managed and what Shanna was doing with
11 the family finances. And you've identified as a risk factor his
12 attempting to freeze the victim's bank account in an effort to
13 control her spending. I take it this would fall into the
14 category of coercive control or economic abuse or both?
15 **A.** Yes, it would be. Again, it's an individual event but
16 in the broader context, it would fit into elements of coercive
17 control. I think there's also in the file, if memory serves me
18 correct, reference to his concern about her using the family
19 vehicle to go to work or to pursue her education, I forget the
20 details, and his attempt to cut her off from access to a
21 vehicle. Then, in fact, I think her father had to put a down
22 payment down on getting a truck. That's from my memory. I hope

1 that's accurate.

2 **Q.** Right, okay. And we've discussed yesterday the next
3 risk factor which is present here, which is the perpetrator
4 having choked or strangled or I guess attempt to choke or
5 strangle the victim in the past. Again, as we discussed
6 yesterday, that seems to be a particular form of physical
7 contact, a physical violence that is of concern in domestic
8 relationships, even above and beyond any other kind of physical
9 contact, is that correct?

10 **A.** Yes, because it's life threatening. Obviously,
11 strangling somebody, you know, can lead to death, lead to
12 serious injury. So it would be certainly an element of high
13 risk.

14 **Q.** Access to or possession of any firearms that's, I
15 guess, self-evident here, obviously, that Cpl. Desmond had a
16 possession acquisition license and was able to buy firearms, so
17 he had access to firearms.

18 The next one is the victim's intuitive sense of fear of the
19 perpetrator. We talked a little bit about that yesterday as one
20 of the newer risk factors and, in this case, given her call to
21 the Naomi Society and some expressions of fear to her family
22 members, that would constitute, would it, an intuitive sense, a

1 fear, I guess, even if she's unable to articulate exactly how
2 that might manifest itself?
3 **A.** Yes. I mean it is certainly documented that she is
4 fearful. She is saying that to others and I think at times she
5 said that to Lionel in response to his conduct. So it's
6 certainly concerning.
7 I'd also note, I think I put this in the report, there's
8 also some ambivalence. You know, she's fearful but she's also
9 trying to manage the situation. So she discloses some things,
10 even in the final interviews with Naomi Society, you know, she's
11 obviously concerned enough to be asking for information about a
12 peace bond where you're really trying to get somebody to stay
13 away. But then, at the same time, you know, when asked
14 directly, you know, she doesn't feel that either she or her
15 daughter are unsafe. So it's a bit of a mixed message. But,
16 again, I would say it's not uncommon to have a victim trying to
17 manage a situation and, in fact, she's giving off mixed
18 messages. So I try to picture myself, you know, taking that
19 final call at the Naomi Society.
20 And, again, I'm not second guessing what happened but, you
21 know, from a counsellor's perspective, you are getting mixed
22 signals. On the one hand, you're saying, How do I get a peace

1 bond? Well, why do you want a peace bond? You want a peace
2 bond because you want to keep somebody away from you. You know,
3 you're also asking information about Family Court because,
4 obviously, you're looking to protect your daughter and figuring
5 out how to manage custody and access or parenting plans. But,
6 at the same time, you're saying you're not feeling unsafe. So
7 certainly you're getting a mixed message, you know, which is
8 challenging. But the bottom line, she's still expressing fear
9 and concern.
10 **Q.** Ambivalence, you say, is not, and I would assume it's
11 not uncommon, separation is a process, not a single event,
12 necessarily.
13 **A.** Yes, again, it's analogous to calling the police and
14 saying, I just want this to stop. I don't want him charged, I
15 don't want him in jail. You know, I just need help right now
16 until things calm down. There's ambivalence in terms of how
17 much you say and what you do to follow through.
18 There's also the other, and again I'm not, this is pure
19 speculation. The minute you talk about feeling unsafe, the
20 minute you're disclosing violence, it has implications for
21 police involvement. It has implications for child protection.
22 You may be saying, you know, I'm unsafe, I'm not sure I can

1 manage the situation. And there is a reality that you might be
2 concerned that child protection may get involved, which could be
3 helpful or it could escalate things, depending on the
4 circumstances.
5 **(10:50)**
6 **Q.** Which is a concern for a victim in reporting those
7 things, are all going through someone's head, I suppose, when
8 they're trying to deal with how to manage the situation.
9 **A.** Yes, and I mean taking it away from the specific facts
10 in this case, you know, if you're a woman in Ontario and being
11 abused, the minute you call the police, you're going to lose
12 control of that situation because, if the police hear about an
13 assault and they have reasonable and probable grounds, they have
14 to pursue charges whether or not the victim wants charges. They
15 also, if there's children in the home, the police have to file a
16 report with Child Protection to do an investigation to make sure
17 the children are safe. So that police call will trigger a
18 number of things that follow. So that's, that always creates
19 ambivalence for a victim calling the police. Or some victims
20 are not sure what's going to happen and, for other victims, they
21 may be hesitant to call because they're concerned about what
22 will happen.

DR. PETER JAFFE, Direct Examination

1 **Q.** You've identified as the final grouping, I guess. I
2 don't know if these were in your formal count as risk factors
3 but you've identified them as other factors that, I guess, are
4 relevant to an assessment of risk. How would you categorize
5 these particular facts as they relate to a risk assessment?
6 **A.** They weren't formally added in terms of the number of
7 risk factors but there are things that in our Death Review
8 Committee reviews, we all add additional factors which, you
9 know, don't appear as formal risk factors but they're important
10 contextual factors. So, in this case, I thought it was
11 significant that Lionel Desmond indicated that he had suffered
12 head and back injuries and the problems that he had. And,
13 obviously, those problems were subject to the thought there
14 should be follow-up, neuropsychological assessments.
15 There's also other factors in terms of concern that he had
16 stopped taking the medication. So there's concern about
17 compliance with treatment. Because often a risk management plan
18 may be that somebody has their behaviour more under control when
19 they're following medical direction. So there's concern that he
20 may not be complying.
21 There's concern about financial issues. So it's part of
22 the downward spiral of his life at this point. He's not sure

1 where he's going to live. Even when he leaves Ste. Anne's, he's
2 not sure about how he's going to manage or he's going to live.
3 There's concern about declaring bankruptcy. Concern about
4 needing to access the food bank. So there's serious concern
5 about being able to look after himself.
6 There's also concerns, just in general about, you know,
7 leaving the military and being able to adjust being a civilian.
8 And beyond that, even navigating the system to get assistance.
9 Also, concern about sleep issues. Obviously, somebody who
10 is not sleeping is another concern in terms of their mental
11 health and mental well-being. And also earlier concerns about
12 him being unfit to operate a weapon but still potentially having
13 access to weapons.
14 There's another comment I have in my report and it wasn't
15 in the appendix, but also there's erectile dysfunction that are
16 in the medical records, which are certainly a concern and
17 certainly in terms of him feeling, obviously he's threatened
18 that in his own mind that Shanna is seeing other men, that he's
19 concerned about his own sexual functioning and performance so it
20 also undermines his sense of masculinity, who he is. So it's
21 another factor in terms of the overall context.
22 **Q.** Right. So some of these, although they're not

1 categorized as formal risk factors from the literature, I take
2 it then there are things that you see repeatedly in your death
3 reviews, things like perhaps financial problems or physical
4 issues, that type of thing, that do recur in the cases that you
5 examine. Do I understand that correctly?
6 **A.** Yes, and more importantly, they offer a broader
7 context of the issues and the challenges. Going back to our
8 discussion yesterday about actuarial assessments versus more the
9 structured approach. You know, an actuarial, if you're doing
10 the ODARA, you're making one of 13 checkmarks. If you're doing
11 something like B-SAFER, these are things that you would add in
12 your clinical notes to provide more context and these are issues
13 you would also be wanting to address in terms of risk
14 management. For example, you know, if Lionel Desmond is going
15 to function in his community, he's going to need proper housing,
16 he's going to need economic support. Even things that have come
17 up in the clinical notes in terms of, for example, an issue that
18 was important to him was physical fitness and not being able to
19 have the funds to join a gym. So there are some things that may
20 be critical in terms of his adjustment to being a civilian and
21 managing independently in the community that would be critical
22 to his care.

1 **Q.** If we go back to the PowerPoint you created, Exhibit
2 344, you had included a slide, and this would be at page 31, I
3 believe, a slide particular on victim vulnerability and we
4 talked about that a little bit yesterday. I wonder if you can
5 comment on whether Shanna Desmond would, I appreciate there are
6 certain particular factors that give rise to someone being
7 categorized as a vulnerable victim, but were there particular
8 things about her or Aaliyah that would have been constituted as
9 vulnerable victims, I guess?
10 **A.** Yes. So I didn't check off that in my first review,
11 and again in reviewing the file and working on the report, I
12 spent a lot of time thinking about these issues and I thought
13 after I completed the report, subsequent to submitting it to
14 making sure it was, you know, I made the deadline required, I do
15 think victim vulnerability would be another factor.
16 I do think for Shanna and Aaliyah living in a rural
17 community, I think is an important factor. And also potentially
18 being in a more isolated cultural community in terms of, you
19 know, being an African Nova Scotian and what that would mean in
20 terms of your identity, in terms of potential trust of outsiders
21 or other agencies to become involved in your life. So I think
22 that would be another factor that we would want to consider in

1 the circumstance.
2 **Q.** Okay. So, again, we're at about 20 of the risk
3 factors present and you said yesterday that for the Death Review
4 Committee in Ontario, seven is sort of your pivot point, I
5 guess, where you say this could have been ... homicide was
6 predictable and could have been prevented. Do I understand that
7 correctly or recall that correctly?
8 **A.** Yes. This is certainly an extreme case. You know,
9 certainly if ... I'm thinking, and I may be getting ahead of
10 myself or your question, but I think if you were looking at
11 sometime in December, you know, at a point December 2016,
12 there's a point, there's a number of, I thought, very thoughtful
13 assessments, I want to make sure I get the name right, but there
14 was a Dr. Slayter who was the psychiatrist.
15 **Q.** Yes.
16 **A.** I thought he had a very comprehensive assessment
17 without having all the information he needed. So I have a
18 fantasy, if we went back to December 2016, if Dr. Slayer had
19 said, You know, I'm really concerned, as he was concerned.
20 Certainly, his assessment is certainly concerning about all the
21 circumstances.
22 If he had pulled together a community conference, if he had

1 said, I want to have a conference, I want to involve previous
2 service providers, you know, through Veteran Affairs. You know,
3 I want to have multiple people that have been involved and I
4 want to sit down and look at, you know, the risks that are
5 present and what the plans are going forward in terms of keeping
6 Lionel Desmond safe and keeping Shanna safe, and Aaliyah, I
7 think there would have been overwhelming information that, you
8 know, a safety plan and a risk management strategy could have
9 been, should have been put in place. So all the information was
10 potentially there but not available to him at that time for a
11 number of circumstances that I know are the subject of this
12 Fatality Inquiry.
13 **(11:00)**
14 **Q.** Right. I'd like to follow up on that point and you've
15 referenced, for example, Dr. Slayter's report from late in 2016
16 when he had very little information and, as you say, did a very
17 comprehensive report. But one of the things that many treating
18 professionals struggled with is access to information and this
19 idea of silos where information isn't shared forward with other
20 treating professionals and that's true, I think, of the mental
21 health treatment that Lionel Desmond received, but obviously
22 also the risk factors for domestic violence.

1 And I might actually just refer you to a passage in your
2 report, and I'm just quoting from the bottom of page 27 of your
3 report and I'll get you to comment on it. You say:
4 One of the critical observations I would
5 make is that each risk factor and incident
6 that brought it to light (ie. disclosure to
7 friends, family, professionals, was treated
8 as an individual event rather than as part
9 of a broader context of the ongoing history
10 of the situation. Every event needed to be
11 considered in the context of the length and
12 depth of this couple's difficult history and
13 the alarming patterns of behaviour. For
14 example, his presentation at hospital for
15 psychiatric consultation near the end was
16 limited by the lack of access to all prior
17 assessments and attempts at intervention.
18 The focus became whether he said he had
19 intentions or plans to kill himself or
20 others that day. The focus should have been
21 on his alarming history and accumulated risk
22 factors to that point. Each new service

1 provider should have been aware of the
2 mountain of risk factors to deal with if
3 they had had access to prior assessments and
4 could have coordinated with previous service
5 providers.
6 So I'm going to get you to comment on that but that's, I
7 take it from what you're saying, a struggle that service
8 providers had in identifying and understanding the risk factors
9 when they didn't have the full history. Is that where you're
10 going with that, Doctor?
11 **A.** Yes, I think that summarizes my views. I guess I
12 would go beyond that. Sometimes working in silos or concerns
13 about confidentiality is really an excuse for not collaborating.
14 So all the legislation we have, whether it's Nova Scotia or
15 Ontario, about confidentiality and protecting information about
16 patients or clients is trumped when you're concerned about risk
17 of harm and providing the best service possible.
18 I think in this situation, in looking at the records,
19 Lionel Desmond was desperately seeking help. He wasn't saying
20 to anybody I don't want you to see my records, you know, he was
21 trying to get access to records. He wanted to make sure that
22 Dr. Slayter or others, you know, would know the history, in the

1 same way, you know, Shanna would have wanted that.
2 So, in my view, there's no reason why prior service
3 providers, you know, couldn't have written a summary and
4 forwarded it and, you know, offered their email address and cell
5 number for follow-up.
6 I think to me it's patently obvious at many points when he
7 leaves Ste. Anne's Hospital and he's anything but stable,
8 there's ongoing concerns, there's no reason why service
9 providers couldn't say, you know, Lionel, I'm worried about you.
10 You know, you're going back, you don't have any place to live,
11 you know, we witnessed firsthand the conflicts with Shanna, it's
12 important to have a summary that we can provide to, you know, a
13 doctor in your community. Someone is going to have to follow
14 up. I know you're anxious to get home now because you want to
15 spend time with your daughter before school starts and if you
16 want to do that that's your right but it's important that we
17 connect you with somebody in that community to provide ongoing
18 support.
19 So I think there's lots of ways information could have been
20 shared and obviously there's some cases where people don't want
21 anything shared. I think in this case what I see all over the
22 file is that Shanna is anxious to get help, you know, for her

1 husband and Lionel Desmond is anxious to get help for himself,
2 and this information could have been shared readily with their
3 consent rather than waiting for him to land at somebody else's
4 doorstep and getting a release signed and then tracking down
5 that information.
6 **Q.** Right. And the information sharing part of this, you
7 know, Dr. Jaffe, is not just obviously healthcare records but
8 obviously concerns about risk factors for domestic violence.
9 You see ...
10 **A.** Yes, I'll ...
11 **Q.** Go ahead.
12 **A.** No, definitely it's a whole ... I mean because there's
13 ... as I mentioned yesterday there's two major issues here. One
14 is significant mental health problems and how they get managed
15 and there's also serious concerns about the risk related to the
16 history of problems in the marriage that are certainly
17 escalating, so both areas of concern.
18 **THE COURT:** I'm going to stop just for a second and make
19 the observation that we know that Cpl. Desmond on October the
20 12th or thereabouts I think he called VAC making a request for a
21 copy of his discharge summary from Ste. Anne's which I believe
22 was under the control of VAC at that point in time. So that was

1 on October the 12th, and presumably if he'd been able to get a
2 copy of it then or shortly thereafter when he arrived at St.
3 Martha's Hospital on October the 24th in crisis with his wife he
4 would have had it in hand. Thank you.
5 **A.** Yes, Your Honour, and Dr. Slayter would have been, I
6 think, in much better position to understand the depth of the
7 issue and the need for immediate planning.
8 **THE COURT:** Certainly. Thank you. Sorry, Mr. Murray.
9 Thank you.
10 **MR. MURRAY:** And I'm just wondering as well, Dr. Jaffe,
11 we talked about risk assessment tools and had a risk assessment
12 tool been done, one of the variety or risk assessment tools that
13 we referenced yesterday along the way and that could have been
14 part of the, I guess, sharing with other professionals would you
15 see that as a potential benefit for future service providers to
16 keep the family safe?
17 **A.** Yes, I think obviously there was a concern about
18 suicide and checking in with Lionel Desmond as to whether he had
19 any immediate plans to kill himself and how he would go about
20 doing that, but there was no risk assessment looking at domestic
21 violence and potential for domestic homicide given the severity
22 of the conflict that was reported even at Ste. Anne's. And I

1 may be wrong in the details but even at the point of discharge
2 there was either a joint session either on the phone or in
3 person where they, Shanna and Lionel, can't even keep it
4 together in terms of talking about the future. There's so much
5 conflict that the call has to be cut off. Again, I apologize
6 for not remembering whether it was in person or a phone call,
7 but even after that he's being discharged at his request and
8 he's going back to that community in that state, so certainly
9 having the risk assessment.
10 I would have even seen there was enough warning I think at
11 Ste. Anne's to even doing a danger assessment with Shanna at
12 that point saying ... you know, talking to her alone and asking
13 her about, you know, her concerns and her fears and going
14 through a checklist would have been critical.
15 **Q.** Dr. Jaffe, you were kind enough to do a number of
16 recommendations for us to consider but before we move on to the
17 recommendations I want to ask you if, beyond what we've said, if
18 you have other overall impressions of this situation and of the
19 tragedy and how it played out and what might have been done.
20 **(11:10)**
21 **A.** I think we've covered the highlights and I think the
22 recommendations probably are all based in my findings from the

1 file review in terms of issues that are important. Certainly
2 throughout the file I see a theme that we see in our death
3 review cases in Ontario, which is a lack of collaboration.
4 That's the issue we just talked about; people working in silos,
5 not sharing information, not getting together. So a lack of
6 risk assessment, a lack of planning together, you know, across
7 sectors is certainly an overwhelming theme.
8 **Q.** You've summarized, again, the various recommendations
9 that you've made for us, they're in broad categories and there
10 are, I guess, specific suggestions under each recommendation so
11 I thought it would be appropriate for us to look at those, and
12 perhaps we could go to the PowerPoint and it would be page 33, I
13 believe, or slide 33.
14 Your first recommendation is in the area of the expansion
15 of public education on domestic violence and domestic homicide
16 including the impact of domestic violence on children, and you
17 make reference to neighbours, friends, family and co-workers.
18 So, I guess, generally speaking, to begin with, I take it
19 you feel there's still room for improvement and work to be done
20 on educating the public on issues of domestic violence and
21 domestic homicide?
22 **A.** Yes. I mean this would be true in Nova Scotia but it

1 would be true all over Canada. So obviously, you know, there
2 are some efforts underway. And I noted, you know, from
3 testimony you received from the Nova Scotia government that
4 clearly there are things currently underway, so my
5 recommendation is really to enhance the work that's being done.
6 And the particular issues identified is recognizing the fact
7 that domestic violence can be lethal, which often is overlooked.
8 And also recognizing that suicide threats certainly during
9 separation/divorce proceedings are a significant red flag and
10 could be a form of domestic violence themselves. So being able
11 to open people's thinking that those two issues can be connected
12 and not just focusing on one issue.
13 I also indicated the importance of looking at challenge in
14 the culture of silence particularly in rural communities but
15 it's often an urban issue as well. That domestic violence isn't
16 something that's just inevitable that has to happen and being
17 able to speak directly to victims and perpetrators.
18 So yesterday I think I mentioned in my testimony that when
19 we do public awareness sessions we do sessions with community
20 groups, schools, colleges, universities where we actually role
21 play about how you might talk to a victim and perpetrator. You
22 know, how do you engage somebody in getting help without judging

1 them, you know, for living with abuse somehow that's their
2 failing.
3 You know, how do you talk to a perpetrator. Hopefully when
4 he's not angry and sober when you can talk to him and saying,
5 you know, You know, John, I'm worried about you, I'm worried
6 about what's happening in your family, you need help. How do
7 you approach somebody in those circumstances?
8 And I also indicate that when we're doing campaigns ... in
9 Ontario, as I mentioned yesterday, we have four different
10 campaigns for immigrant/refugee population and one for
11 Indigenous and one for francophone. So certainly, you know,
12 Nova Scotia has its own unique culture as a province and you
13 also have unique cultural communities and I think there's a
14 long, rich history with the African Nova Scotian community so
15 obviously making sure that any public education campaigns are
16 inclusive of them. And again, these campaigns have to be done
17 in a sensitive manner. You know, the minute you have a public
18 education campaign and it's directed towards one community
19 you're not saying that it's more of a problem in that community
20 but you do want that community to recognize that they're part of
21 a broader social problem and they may have their own solutions
22 that they want to talk about.

1 One of the things I've indicated and, again, this
2 PowerPoint slide is obviously a summary of a more detailed
3 recommendation in the report. One of the things I noted that
4 this public education has to be as broad as possible, that it's
5 not just having brochures, you know, or having a passive
6 website, obviously you have to use social media, you have to
7 advertise, and I used a very specific example. You know, an
8 example I used was Hockey Night in Canada just as a very
9 concrete example. It's one of the most widely watched
10 television programs and I found an example recently on the
11 francophone site in Quebec during a broadcast of a Montreal
12 Canadiens game they actually had an advertisement which focused
13 on psychological and emotional abuse in a marriage and focused
14 on the importance of men taking responsibility. And I was
15 struck by the vast audience. I'm thinking about the hundreds of
16 thousands of viewers of that show and a way of certainly
17 engaging men and women and the general public on this topic.
18 **Q.** Dr. Jaffe, it may test our technological know-how here
19 but we may be able to play that video and have a quick look at
20 that public service spot.
21 **A.** That would be great if it's possible.
22 **Q.** This is in French, I believe.

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1 **VIDEO PLAYED (11:17 hrs.)**
2 **https://www.bing.com/videos/search?q=Choisir+la+vie&docid=608018**
3 **308093513567&mid=E35716BE7CF32C4D95BFE35716BE7CF32C4D95BF&view=d**
4 **etail&FORM=VIRE**
5 **VIDEO CONCLUDED (11:20 hrs.)**
6 **A.** I know there are multiple ads. Actually, the one I
7 had intended is only a 30 second one that has no physical
8 violence, it's only emotional and psychological abuse and it was
9 ... anyway, there are multiple versions of this but obviously
10 it's very, very powerful.
11 **Q.** And a public service announcement that's, as you say,
12 targeted to a particular audience or a broadcast at a time to
13 reach, I guess, the widest audience you see as something that's
14 necessary and beneficial?
15 **A.** Yes, I think that's critical. It can't be passive. I
16 mean even having brochures in a doctor's office, in your family
17 doctor's office, most people are even hesitant to take a
18 brochure for fear of revealing what their problem is by taking
19 that brochure. So it's talking about a much broader media
20 campaign and engage in the community, engaging both men and
21 women. And just a critical thing, men have to be engaged.
22 You know, we often think about domestic violence somehow it

1 being a woman's issue and I think the ads really have to reach
2 out to men, not only to men who are abusive who need to think
3 about their behaviour but also to their friends and brothers and
4 co-workers to find ways to reach out to them to get help before
5 it's too late.
6 **Q.** And, as we know, younger adults have a tendency to
7 watch less television perhaps and be on social media. Do you
8 see value in attempting to education the public, especially
9 younger members of the public through social media campaigns?
10 **A.** Yes. And that's actually ... in our center we've
11 taken aspects of our Neighbours, Friends and Family campaign and
12 directed them to high schools. So we have a series of
13 presentations to engage youth on the issue so we can look at
14 public education in terms of when this issue starts, in terms of
15 dating violence and dating relationships.
16 **Q.** On the issue of particular cultural communities, and I
17 think it's an interesting point you make that obviously you want
18 to reach those communities but you don't want to leave the
19 impression that there's a particular or unique problem in those
20 communities. How do you address that challenge, for example,
21 reaching particular cultural communities?
22 It's a bit of a broad question, I appreciate, because

1 there's an endless array of potential communities but how do you
2 tailor your public education campaign to particular communities?
3 **A.** You work with that community. So, you know, it
4 wouldn't be right for myself or a small group of people to
5 design a campaign without consulting with the communities
6 involved. So obviously if you're designing something you want
7 to make sure it resonates within the African Nova Scotian
8 community. You want to get representatives of that community to
9 get their ideas and preview any material that's developed to
10 make sure it's appropriate and the message would be well
11 received.
12 **Q.** There are a couple of other subpoints in the report
13 under Public Education that I may get you to comment on. One is
14 promote an understanding of the role of the police, including
15 the importance of contacting police immediately and reporting
16 concerns where individuals are aware of those who have potential
17 access to firearms and who are in a relationship where domestic
18 violence is suspected.
19 Can you comment on that and the importance of that?
20 **A.** Yes. Part of that relates to my testimony yesterday
21 in the sense that many people think you can only call police at
22 a point of crisis and not do enough on a preventative basis. So

1 I think it's important that victims or family members reach out
2 to the police to consult, to say I'm worried about this
3 situation, I'm worried about, you know, the presence of weapons.
4 I mean, certainly Shanna did that, you know, based on the
5 message that she'd gotten from Lionel when she was concerned he
6 was going to go in the garage and kill himself and obviously she
7 reached out at that point. But you would encourage other
8 friends or family members to reach out and seek advice from the
9 police about how to proceed rather than waiting for a point of
10 crisis.
11 This is more at the level of collaboration. We have one
12 program in Ontario in Waterloo Region where the police are part
13 of a Family Justice Centre. So the police are housed together
14 with Legal Aid and Victim Services and counsellors and Housing,
15 so it's one-stop shopping. And victims can make an appointment
16 and talk about what they're dealing with on a more plan basis
17 rather than waiting for a point of crisis and they can get
18 referred to other service providers to get help. So it's
19 creating a whole different mindset, not waiting 'til things are
20 out of hand but trying to get help and plan both around safety
21 and managing risk.
22 **Q.** You had made a recommendation that we should make the

1 potential links between domestic violence and post-traumatic
2 stress disorder and that these links should be part of a public
3 and professional education campaign for military personnel,
4 family members and professionals providing treatment for
5 military personnel.
6 Harkening back to our discussion yesterday about the very
7 legitimate concern about not stigmatizing mental illness but
8 balancing that with the need to recognize that certain mental
9 illnesses can increase risk, how do you do that and what should
10 that kind of education campaign look like?
11 **A.** I think my response to some of these questions will be
12 more than something that has to be designed by a committee.
13 Thinking about this, you'd obviously want to involve Veteran
14 Affairs because this is obviously a sensitive issue.
15 On one hand, I'd say there's a lot of veterans'
16 organizations that are involved in public education on PTSD in
17 the aftermath of serving in the military and trying to, you
18 know, raise public awareness and support and making sure there's
19 appropriate service providers, and this would be going beyond
20 that to make sure that military families understand what they
21 may be dealing with as somebody adjusts back to civilian life.
22 And, again, this would have to be done in a very sensitive

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1 and thoughtful way. Most people with PTSD are not violent, so I
2 want to be clear. The message has to be very thoughtful because
3 you're not saying that everybody who leaves the military is
4 going to be involved in domestic abuse, everybody with PTSD is
5 going to be violent, but you want to raise the issue that this
6 does pose a potential risk compared to other mental health
7 disorders and there needs to be appropriate treatment and
8 monitoring. So clearly it has to be done in a very thoughtful
9 way.
10 **Q.** Thank you. And one other I wanted to comment on and
11 you've commented on this yesterday and you used the example of
12 the Toronto Blue Jays, but using workplaces as a pathway to
13 reach adults, in this case in Nova Scotia, with public education
14 campaign programs. You see workplaces, all variety of
15 workplaces, as a space to help with that public education
16 campaign?
17 **A.** Yes. I mean workplaces are ideal. I mean, given the
18 fact that research tells us 50 percent of domestic violence
19 victims their violence follows them to work. It's not like home
20 and work are two different places when it comes to domestic
21 violence. If you're being abused at home it's going to follow
22 you to work. It's going to be harassing messages, your

1 partner/ex-partner showing up at the workplace, getting
2 disruptive phone calls.
3 Our center was involved in a national study with over 8,000
4 Canadians and what we found repeatedly is that victims report
5 the violence comes to work, and also co-workers report that they
6 have firsthand experience seeing the aftermath of domestic
7 violence in the workplace. So this is obviously an important
8 venue for public education and it's welcomed.
9 I've been involved in many programs in workplaces to talk
10 about these issues and, to be frank, sometimes I'm called in to
11 do this reluctantly; somebody in the HR department says we have
12 to do this to comply with the laws in Ontario, they don't really
13 have their heart in it, just to be frank. And it's usually
14 welcomed. Usually, we have to cut off questions. You know,
15 people want to talk about not only the workplace but they want
16 to talk about concerns about, you know, their sons or daughters
17 and dating relationships or things they've dealt with in the
18 past. And it creates permission to have more open conversations
19 about this and then victims and perpetrators know that they're
20 not alone and there is help that's available.
21 **(11:30)**
22 **Q.** Your second, I guess, broad category of

1 recommendations is on the other side, would be the expansion of
2 professional education on domestic violence and domestic
3 homicide, including the impact on children. And we, again, had
4 this discussion yesterday that, on occasion, professionals who
5 deal with individuals, who treat individuals may not be fully
6 aware of the risk factors for domestic violence and domestic
7 homicide, may not identify it. What do you have to say about
8 how we would be able to address that?
9 **A.** Well, I think in 2021 there's no excuse for not
10 knowing about domestic violence and the impact it has. So I
11 think this is an issue that crosses all sectors. You know,
12 whether you're a teacher in a classroom dealing with children
13 who are suffering from the aftermath of exposure to domestic
14 violence or whether you're a psychiatrist, social worker, or
15 psychologist in a healthcare or mental health center, or social
16 service professionals, I think it's important to be up to date.
17 So it should be covered as part of ongoing professional
18 development.
19 And I also think one of the things that I certainly
20 recommended that there'd even be, whenever possible, cross-
21 training so you have people in different systems being trained
22 together. That's certainly one issue we've pursued in Ontario,

1 getting advocates for abused women working together with Child
2 Protection so they can see common interests and identify
3 protocols and strategies that may be more effective in terms of
4 communication and collaborating to help families in these
5 circumstances. So I think training is essential.
6 I think one of the issues that I mentioned yesterday is I
7 think everyone should be aware what domestic violence is and
8 what the risk factors may be for lethality. Individuals may
9 differ in terms of whether they're going to limit their
10 knowledge to just screening for lethality in the sense of being
11 aware, for example, of firearms or recent separation, a history,
12 being aware of the basic risk factors and then saying to a
13 client or a patient, This is not my specialty area but I'd like
14 to refer you to, you know, somebody from Naomi Society who has
15 more in-depth information and can do risk assessment or if
16 there's imminent risk of harm, being able to engage with the
17 police in that community.
18 So I think that's an important starting point. I think I
19 mentioned yesterday is also an issue where you're ... if you
20 want to engage the legal sector, family lawyers; you know,
21 criminal lawyers, judges, this is an issue I think for everyone
22 to stay up to date.

1 We've had great ... just another ... I want to also think
2 of positive examples. I know that now that with the **Divorce Act**
3 changing to include coercive control, there's much more legal
4 education going on on this issue. The Law Society of Ontario
5 now has a number of programs in the month of November with
6 hundreds of registrants.
7 Our Death Review Committee made this recommendation several
8 times and I know lawyers who are anxious to keep up their
9 professional development credits. We had a thousand lawyers
10 several years ago attend the session on our Death Review
11 Committee recommendations and risk factors. So I just use those
12 examples. There is a lot of interest, but these opportunities
13 have to be provided and promoted on a regular basis.
14 **Q.** Right. Both for professionals in training and for
15 ongoing education for professionals in their work.
16 **A.** Yes. So it's both aspects. Obviously, I think in my
17 recommendation I outlined you certainly want to get to the deans
18 of medical schools and law schools and schools of social work
19 and psychology to make sure that treating happens, you know,
20 right at the outset of someone's career. But then you also want
21 to provide it as part of ongoing professional development
22 opportunities.

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1 Another issue outlined on the slide is also mental health
2 professionals. I'd say one of our most common recommendations
3 are directed towards mental health professionals who often know
4 a lot about depression and suicide and are screening for suicide
5 but never ask questions about homicide or homicidal ideation
6 even in those cases where there's a history of domestic violence
7 and there's clear warning signs.
8 We've found in a number of cases where someone has gone to
9 a hospital emergency room in Ontario and they've talked about
10 depression and suicide and there's all kinds of protocols around
11 suicide risk and the issue of domestic violence and homicide are
12 nowhere to be found on any protocol or any assessment. So this
13 is something that shouldn't be happening in 2021.
14 **Q.** And you focus, obviously some of the recommendations
15 in particular, on professionals being cognizant of the risk of
16 firearms being available to individuals in particular when they
17 are suffering from some mental health such as depression. Do
18 you see that as something that's particularly important for
19 continuing ongoing education?
20 **A.** Yes. I think knowledge about firearms ... I mean the
21 research is pretty clear about the risks of having firearms in a
22 home or access to firearms related to suicide and homicide. So

1 I think that should be a regular conversation in these
2 circumstances. It shouldn't be an exceptional discussion. It
3 should be a basic discussion. And I'd say especially in rural
4 communities, but certainly in every community.
5 I think just looking at the slide, I think I already made
6 the comment about the next generation of practitioners. But,
7 also, I think one of the points I made, this should be brought
8 to people's attention through their regulating bodies. You
9 know, I mentioned yesterday that, you know, the most recent
10 issue of the bulletin that I get through the College of
11 Psychologists in Ontario, there's a note about domestic homicide
12 risk assessment and there's actually a reprint of a case that
13 the Ontario Death Review Committee reviewed. And, that way, it
14 gets to everyone's attention because people tend to take
15 bulletins from their regulating body very seriously.
16 **Q.** Do you see value in increased training, not just for
17 professionals, not just in the area of domestic violence, but
18 specifically for many professionals I guess in the use of risk
19 assessment tools? As a psychologist, yourself, for example, or
20 psychologists who are being trained, do they have enough
21 familiarity with the risk assessment tools for domestic violence
22 and domestic homicide?

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1 **A.** They don't, but it's increasing. There's certainly
2 growing awareness. And I do think an important point is the
3 distinction between screening and risk assessment. So there's
4 different comfort level. So some, for example, family
5 physicians, you know, obviously they should know what domestic
6 violence is in all its forms and they should know common risk
7 markers and be aware of concerns about firearms. But they may
8 not have the time or the training to be involved in the detailed
9 risk assessment.
10 So people have to know enough to be alert to the issues but
11 also know when they want to refer something to another
12 professional who may have expertise in the community, whether,
13 you know, in this context, whether it's the RCMP, you know, who
14 should be specialists in risk assessment or whether it's to
15 Naomi Society who are dealing with abuse on a regular basis. So
16 there might have to be a referral.
17 **Q.** Right.
18 **A.** And actually this is an aside, but just an example I'm
19 talking about. When I get my annual checkup with my family
20 doctor, I always bring along a copy of the Death Review
21 Committee Annual Report because I feel, you know, it's part of
22 my education, you know. And he always very politely says, Thank

1 you for sharing this. I won't have any time to read it. Can
2 you give me the highlights?
3 So I give him the highlights. And then he says, The best I
4 can do is I can be aware, but if I'm concerned about these
5 issues, I'm not going to have time. I'm going to have to refer
6 this to the nurse or the social worker in my medical practice.
7 And I said, Well, that's good enough for me. That's a good
8 start.
9 So then I'm just using that as a very concrete example of
10 somebody who cares. My family doctor cares but he has no time
11 or specialized training. But at least I want him to know enough
12 of when he's going to move it up in terms of additional
13 assessment.
14 **(11:40)**
15 **Q.** Right. So, obviously, the appropriate tool for them
16 or the appropriate avenue to reach another professional for them
17 to be aware of that, I think you had said in one of your
18 recommendations, you said:
19 All frontline professionals that deal with
20 individuals and families in crisis should
21 adopt an appropriate risk assessment process
22 and a mechanism or protocol at local and

1 interprovincial levels to facilitate and
2 enhance communication between agencies and
3 professionals when a person is identified to
4 be at risk.
5 So it's having the appropriate, as I understand you, the
6 appropriate risk assessment process and knowing then where to
7 refer people when there is a concern. Do I understand that
8 correctly?
9 **A.** Yes. And, in fact, I would say that Nova Scotia has
10 been a leader in terms of creating some protocols and policies
11 in this area. So there's been some very innovative work that's
12 developed that stems back from a prior homicide and a prior
13 review some 20 years ago. And I think one of the challenges
14 that we face in this field, sometimes there's great initiatives
15 but they're not sustained or known on a more wide-spread basis
16 and that's a challenge.
17 So sometimes in our Death Review Committee, you know, we
18 find we're repeating ourselves. And repeating ourselves is not
19 necessarily a bad thing because repeating yourself to make sure
20 the message continues to get out. And sometimes it has to be
21 repeated and people need to be reminded of what resources they
22 have available.

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1 **Q.** Right. And when you made reference a moment ago and
2 this, I guess, leads us to the third recommendation or area of
3 recommendations which you've entitled, Police Risk Assessment
4 and Service Coordination. And I think you may have been
5 referring in Nova Scotia, the High Risk Case Coordination
6 Protocol. You make reference to that in your report. We have
7 one of ... that document, the protocol, marked as Exhibit 341.
8 Bring that up.
9 **EXHIBIT P-000341 - HIGH RISK CASE COORDINATION PROTOCOL**
10 **FRAMEWORK - SPOUSAL/INTIMATE PARTNER VIOLENCE**
11 **Q.** And, interestingly, you say in your report:
12 Nova Scotia has responded to past
13 murder/suicides with a clear commitment to
14 enhance police training and responding to
15 domestic violence as well as to improve
16 coordination across justice and all human
17 services. Nova Scotia has a model
18 framework, the High Risk Case Coordination
19 Protocol, that is supposed to be in place
20 across the province.
21 And you say:
22 Since its inception in 2004, there have been

1 no homicides in cases that have followed
2 this protocol and there are current efforts
3 to augment this work with the highest risk
4 table in domestic violence cases to further
5 these efforts.
6 So ... and that's from the Maxwell George Inquiry that this
7 stemmed from, I believe. So it's your understanding that there
8 have been no homicides in cases that have followed the High Risk
9 Case Coordination Protocol?
10 **A.** That's what's been reported. We had a national
11 conference on domestic homicide earlier this year and we had a
12 speaker from Nova Scotia who's a leader in the field. And she
13 described this development and the pride about the effectiveness
14 of the protocol. I think the challenge is making sure it's used
15 more widely and obviously in appropriate cases.
16 I think in my report I make the comment that there's often
17 a difference in urban and rural centers, that sometimes urban
18 centers with a larger police service you might have more
19 specialists, and in rural areas you might have police who have
20 multiple responsibilities and may not have access, you know, to
21 specialists in the same way. I'm saying that as a general
22 comment across Canada. Obviously I'm not an expert on Nova

1 Scotia and exactly, you know, what the statuses of urban versus
2 rural policing. But it's a comment that would be true, in
3 general, across the country.
4 So, certainly, this is a protocol that would have been
5 useful in this situation. Again, the tricky area is the one
6 that I referred to yesterday, whether the calls that Shanna made
7 to the RCMP or even the call that Lionel made near the end,
8 whether they should have triggered some sort of risk assessment,
9 even in the absence of criminal conduct or the filing of
10 specific domestic violence charges.
11 **Q.** So one of the concerns, and you note this in your
12 report and on your slide, that the High Risk Case Coordination
13 Protocol may not come into play if there isn't a criminal
14 charge.
15 And you've recommended that:
16 The Nova Scotia Departments of Justice and
17 Community Services review and update the
18 High Risk Protocol to deal with cases in
19 which there are no criminal offence but
20 there is concerning behaviour related to the
21 intimate partner; example, concerns about
22 weapons, knowledge, and access to weapons

1 threats to hurt themselves, intuitive fear
2 about others, mental health history,
3 separation or decision to divorce, conflict
4 with other family members.
5 So you see value in expanding the use of an instrument like
6 the High Risk Case Coordination Protocol for situations where a
7 criminal charge may not be laid?
8 **A.** Yes. I think the Desmond situation is an ideal
9 example of a high risk situation, you know, without any charges
10 being laid. I mean given the history, given the suicide
11 threats, given the multiple separations, there would be many red
12 flags where I think the police would want to partner with the
13 community to try to provide assistance.
14 But one of the ironies and I'll just be frank on this
15 issue. One of the things that always seemed strange to me in
16 policing is the aspect that as a police officer you have to say
17 to somebody, I can't really help you until something bad
18 happens. You know? You know, once the assault takes place,
19 then maybe this will kick in.
20 And ultimately, in my view, policing should be about
21 prevention. When someone says, I'm concerned something bad is
22 going to happen, you know, policing should be about crime

1 prevention, homicide prevention, and you shouldn't have to wait
2 for a criminal charge to intervene on a collaborative basis in
3 the community.
4 And, obviously, in this case, even at the end and I forget
5 the date, but there's a call at the end where Lionel Desmond is
6 calling because he can't find his wife and his daughter. To me,
7 that's ... you know, obviously it didn't lead to an intervention
8 but to me that's not a benign call in the context of the
9 previous history in terms of prior police involvement in this
10 situation, both in New Brunswick and in Nova Scotia. So that
11 would have been, you know, in my view, another potential missed
12 opportunity.
13 **Q.** And I guess on that point you suggest:
14 Province-wide training for police and
15 community partners on an updated protocol
16 that reviews lessons learned from this
17 Inquiry. And an important topic to include
18 is working with reluctant, ambivalent
19 victims, who may need to be engaged on the
20 level of the risk they face and the
21 different interventions that may be
22 possible.

1 And you go on to say:
2 The issue of racism and the challenges for
3 African Nova Scotian or other minority
4 groups to reach out to police would be
5 essential.
6 So work in the area, I guess, as you say, of dealing with
7 ambivalent or hesitant victims and how to engage them and where
8 those entry points are, and I don't know how you do that, but
9 what are your thoughts on how you do that?
10 **A.** Well, a starting point, in my view, there shouldn't be
11 a single police officer or Crown attorney in Canada that is
12 surprised to see a victim that is reluctant or ambivalent. That
13 should be the starting point. I mean that should become the
14 norm of what we often see or expect.
15 And how do you engage somebody who's reluctant but may be
16 at risk? How do we prevent things from escalating? How do you
17 work with somebody, you know, who's reluctant or ambivalent?
18 How do we, for example, engage them on even the issue of risk
19 assessment?
20 **(11:50)**
21 You know, how do you say, you know, I'm concerned; you
22 know, we've been here before; you know, you don't really want

1 the police involved, but you've called us a second time. Last
2 time you called, this is what happened. You know? We're
3 worried about you, you know.
4 So, anyway, what I'm really ... at the end of the day, it's
5 really professional development where this is part of what you
6 expect. When I do training at the Ontario Police College, and I
7 was just involved one last month with officers from across the
8 province, and when it came to question period, that's one of
9 their major concerns; you know, how do we deal with people
10 reluctant to have us involved? Say, well, thoughtfully, you
11 know, this is a challenge. Don't be surprised. You know,
12 you're not serving fast food. You're dealing with complex
13 clients and complex situations and you have to find ways to
14 engage them.
15 And, clearly, if they represent different cultural
16 communities, if you're dealing ... for example, I'll use
17 examples from my community. In my community, we may have a case
18 involving a Muslim individual. You know, in our community, we
19 have a Muslim resource center and, depending on the
20 circumstances, individuals who may be more comfortable dealing
21 with their faith community or dealing with specialized
22 resources, you know. So there has to be ways to partner with

1 those communities and those service providers. So we're looking
2 at potentially more nuanced involvement, more nuanced
3 assessments.

4 **Q.** All right. Thank you.

5 Your next slide, I guess following up on the issue of entry
6 points or opportunities for professional bodies or entities to
7 interact with the family, you make reference to one finite, I
8 guess, or specific report to the Department of Community
9 Services in November of 2015 that related not to Cpl. Desmond
10 but to another family member and ultimately did not result in an
11 investigation or a formal investigation.

12 And I take from your recommendation, obviously appreciating
13 you're not commenting on the specific policies or practices of
14 the Department of Community Services in Nova Scotia, but do you
15 see this as the type of entry point or another opportunity for a
16 government agency to have some interaction with the family and
17 potentially identify issues of risk?

18 **A.** Yes. Certainly, Child Protection is a common agency
19 that may get involved in terms of concern about the adult
20 conflict, concerns about the family. Sometimes calls may come
21 from teachers with children in the classroom who are dealing
22 with the aftermath of domestic violence in their home and maybe

1 showing signs and symptoms or making disclosures.
2 So I mean I think obviously part of this fatality review
3 ... the Fatality Inquiry is to prevent tragedies in similar
4 circumstances in the future. So I think there's always lessons
5 to be learned, potentially. There may be none, you know, for
6 people working in Child Protection, but certainly when there's
7 been a contact and then there's a triple murder/suicide that
8 happens after, you think you'd want to have a sober reflection
9 and think about the issues and I'd leave it to that department
10 to draw their own conclusions.
11 **Q.** And more broadly speaking, you've commented obviously
12 that children witnessing domestic violence in the home is a form
13 of abuse itself and children suffer as a result of that. Does
14 there need to be, I guess, more public education on that front
15 that, you know, children who may find themselves in those
16 environments, it may warrant communication with the Department
17 of Community Services?
18 **A.** Yes. That would be part of my first recommendation
19 around public education. It should include the impact of
20 exposure to violence on the children. And as I mentioned, in
21 Ontario we have, I'm not sure about Nova Scotia, but Ontario
22 there's a standard protocol where if there is domestic violence

1 and there are children in the home, that there's automatic
2 filing of a report with Child Protection.
3 **Q.** You make some recommendations broadly that may be
4 directed at the CAF or Veterans Affairs Canada and you say:
5 The CAF or VAC should ensure that high-risk
6 cases are red flagged for immediate follow-
7 up, prioritization of resources, information
8 sharing with community partners and
9 monitoring.
10 This would be page 38. Obviously, we're somewhat limited
11 here in the recommendations that we can make that go directly to
12 federal entities, but your points I think are important. How do
13 you see or what would you see that ... how would you see that
14 happening, I guess, that the high-risk cases are red flagged?
15 **A.** Well, certainly, I mean I think Lionel Desmond would,
16 I think, be a textbook example of a case where everyone would be
17 quite concerned about him. I mean I'm just thinking from the
18 point of him leaving Ste. Anne's. And, again, I know there's
19 lots of evidence and I don't want to sort of repeat myself. But
20 there's a lot of concern.
21 You know, he's leaving a stabilization unit and he's not
22 stabilized. There's great concern about him demeanour, his

1 emotional state. He's going back to community with no place to
2 stay. He's concerned about housing, finances. You know, he's
3 dealing with history of repeated separations, concerns about his
4 wife, concerned about her being unfaithful, concern about, you
5 know, her management of the family finances. And so there's
6 tons of red flags.
7 So that's the kind of case where you'd want to have a
8 follow-up. You'd want to ensure that the receiving community,
9 that there's a professional who's waiting to provide ongoing
10 service and support in these kind of circumstances. I make
11 reference to the, you know, case conference or a warm handoff.
12 And that's a term that I know it's come up before in the
13 Fatality Inquiry.
14 That it's not just, you know, a couple of pieces of paper
15 that follow the veteran, but rather there's a meeting, whether
16 it's a case conference or in-person meeting saying, you know, We
17 want to make sure, you know, that this individual is going to
18 get appropriate follow-up care within the community; you know,
19 given the level of concerns.
20 And this case is not what ... the Lionel Desmond situation,
21 you know, the concerns don't come as a surprise because even the
22 internal documents, looking at their own risk assessment of the

1 likelihood of him being able to adjust well to civilian life
2 raises lots of red flags and concerns. So to me, there should
3 be something that would be ... something that would happen in
4 the normal course of events.
5 And I know this ... you know, again, this is not my first
6 situation dealing with somebody in the military. Obviously,
7 I've been at this for 40-plus years. I have lots of clients,
8 you know, who are veterans who are back in the community. They
9 may be involved in criminal proceedings, they may be involved in
10 family law proceedings. I've been involved in, you know,
11 multiple court cases. In Ontario we've had domestic homicides
12 that involved veterans.
13 And, obviously, it's no surprise that many veterans may
14 have difficulty adjusting to civilian life especially when
15 they're suffering from PTSD and they have multiple other
16 challenges. So this is ... it's not rocket science, if I can
17 say, you know, the needs are very apparent and I think
18 collectively we can all do a better job.
19 **Q.** You've made ... go ahead. Sorry.
20 **A.** Just one ... I hope this is appropriate. I realize
21 this is a provincial fatality inquiry and I realize that the
22 recommendation is directed towards the federal government. Our

1 experience in Ontario has always been that the federal
2 government always listens with both ears open. And I certainly
3 have had positive experiences in the past with the military
4 being open for feedback about these issues, so that's more a
5 personal aside as a professional, yeah.
6 **(12:00)**
7 **Q.** No, fair point. Absolutely. We don't work and live
8 in watertight compartments. Federal and Provincial government
9 interact.
10 So you made a recommendation, Dr. Jaffe, about integrating
11 domestic violence prevention into schools for universal access
12 to information for children and adolescents. It probably can't
13 be overstated how important it is to begin education on issues
14 of domestic violence as early as possible to ensure that young
15 people understand these issues.
16 **A.** Yes. Certainly learning about healthy relationships,
17 you know, begins early. Learning about healthy relationships
18 begins in kindergarten. So obviously, everything that is
19 available within the curriculum and certainly it can become more
20 specific as children get older. There's issues around ...
21 obviously, there's lots that happens in the education system
22 about being aware about bullying, being aware about violence,

1 violence in relationships. You know, sexual abuse, physical
2 abuse, living with violence in the home. You know, disclosing
3 these issues.
4 So I think my recommendation, you know, I hope it would
5 happen across the curriculum and certainly, it can be much more
6 focused in high school, learning about healthy relationships,
7 integrating this within the existing curriculum expectations,
8 you know, for the province.
9 Again, I think my recommendation ... I'm not saying that we
10 need to add a brand new subject called Domestic Violence into
11 high school. What I'm talking about is integrating talk about
12 healthy relationships as a regular part of whether it's health
13 and physical education or other subject areas, making sure that
14 students have a chance to learn about this.
15 This is particularly important for teenagers. In our
16 research we found that teenagers who are living with violence,
17 either living with violence in their home or living with
18 violence in terms of a dating relationship in high school, are
19 five times more likely to talk to their peers than they are to
20 an adult in authority. So the frontline in this work is the
21 peer group and you want to make sure you're educating everyone.
22 Because everyone is going to get involved, whether it's their

1 own relationship or whether it's their best friend or something
2 they've observed or seen at a party or at a social gathering.
3 It's important to have this information.
4 **Q.** And beyond, obviously, education for students you also
5 make recommendations for teacher professional development so
6 that they are also aware of these issues and both are able to
7 identify risk factors that they may see with their students and
8 also to integrate it into the curriculum?
9 **A.** Yes, that would be my hope. I linked to a document
10 that we have in Ontario. It's somewhat dated but on an ongoing
11 basis we've been involved in work with elementary teachers as
12 part of professional development. Actually, the Elementary
13 Teachers Federation has had professional development for
14 teachers across the province, and one of their models is to make
15 sure that every school has a teacher who has particular comfort
16 or knowledge about this issue.
17 So obviously you want every teacher to have the basics but
18 we wanted to make sure that teachers are on staff who may know
19 more about resources in the community and reporting
20 responsibility in dealing with students in these circumstances.
21 So you'd want this knowledge widespread because certainly, you
22 know, we'd estimate, you know, across Canada in the average

1 classroom there's three to five children dealing with the
2 aftermath, you know, of domestic violence. So teachers are on
3 the frontline and teachers will get reports directly, or they'll
4 see it indirectly, through children's play or drawings or what
5 they write or ultimately in high school what they might disclose
6 more directly to them.
7 **Q.** You say the average is three to five students per
8 classroom are dealing with the effects of domestic abuse or
9 domestic violence?
10 **A.** Yes.
11 **Q.** Your seventh area of recommendation is for the
12 creation of a Nova Scotia Domestic Violence Death Review
13 Committee, and obviously, we know that that is now happening in
14 Nova Scotia. I don't know the extent to which ... we've learned
15 a lot about the Ontario Domestic Violence Death Review
16 Committee, how it works, and we have your annual report.
17 To the extent you feel comfortable, do you have suggestions
18 or advice, perhaps, for the Nova Scotia Domestic Violence Death
19 Review Committee in terms of its approach or structure or how it
20 goes about its business?
21 **A.** I think Nova Scotia is in a great place to start this
22 committee because they'll have lots of examples across Canada.

1 So there will be annual reports available, you know, certainly
2 from the neighbouring Province of New Brunswick and elsewhere.
3 You know, obviously, our report ... so there's certainly a
4 foundation. So it's not starting with a blank sheet. There's
5 obviously a lot known about risk factors that could be included
6 and there's a lot known about how to develop a database.
7 I think my only suggestions, things that we've learned and
8 these are things that have developed over the years in Ontario;
9 that we've learned the importance of including survivors,
10 certainly survivors who have done their own healing and have
11 insights to offer. They're, I think, excellent to include as
12 committee members, including diverse community members.
13 Obviously, in Ontario our Committee includes representatives of
14 racialized communities and also Indigenous communities. So it's
15 important to recognize the diversity of the province.
16 Also think of critical issues. It may be hard to have a
17 committee that includes everyone. It should be as diverse and
18 inclusive as possible, but also I think we've learned it's ...
19 although you might not have somebody who's a firearms specialist
20 on as a regular member of the committee it's important to be
21 able to call on those experts to educate the committee before
22 they make recommendations about their ... you know, so they'd be

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1 ... particularly areas of expertise that are important to draw
2 on for individual cases.
3 So those would be some of my highlights, but certainly, the
4 committee is going to have lots of resources to draw on as they
5 develop something that's right for Nova Scotia.
6 The other thing I think I've mentioned in the
7 recommendation that I think it's ... there has been talk at
8 national conferences in the past about potentially having, you
9 know, obviously a death review committee in Nova Scotia but also
10 having that be part of an Atlantic committee. So making sure
11 there's an active partnership, you know, there's a committee in
12 New Brunswick. There's been talk about one developing in PEI.
13 So perhaps having Atlantic meetings to share common concerns.
14 One of the critical issues I think in a smaller province is
15 even though cases are going to be ... the reviews are
16 confidential and the information is not made public, the reality
17 is in a small province people can identify pretty quickly what
18 family one is talking about. So there may be some benefit in
19 reporting out on a more regional basis. So, for example, to use
20 an example, in our national research, in our database that we've
21 developed nationally, we don't report out on particular
22 provinces. We report out on a regional basis to make sure any

1 information from survivor interviews, you know, can't be
2 identified.
3 So that's a special consideration, but I certainly would
4 leave the new committee to partner with others to work on that.
5 **Q.** Just to follow up on a couple of those points.
6 Obviously, one can see the value of coordination regionally for
7 the reasons you've said and just generally for the value of
8 coordinating with other death review committees. Do you know if
9 other provinces in other parts of the country do that?
10 Obviously, Ontario is big enough it may not but do you know, for
11 example, in the west do the provinces coordinate in that way or
12 not?
13 **A.** They don't at this point other than through national
14 meetings. So we do ... there's been at least three national
15 meetings over the last five years talking about death review
16 committees and talking about people learning from each other.
17 There was a subject at a recent conference we held, and
18 actually, that presentation is actually online on our website.
19 So we had representatives from the coroner/medical examiner's
20 office across seven provinces talking about their committee,
21 some of what they're working on, and some of the future
22 developments.

1 And I can certainly send the link and I'm happy to share
2 all the information we have with your medical examiner, I think,
3 who is taking the lead on this issue.
4 **(12:10)**
5 **Q.** Yes. And the importance of ... you say multi-
6 disciplinary. Obviously, you want professionals from a variety
7 of backgrounds on your committee as you have in Ontario. Also,
8 I take from what you say more diverse cultural backgrounds as
9 well?
10 **A.** Yes, I think that's critical.
11 **Q.** I had asked you about the benefits yesterday, and
12 challenges obviously, with death review committees. We don't
13 have, until now, a death review committee in Nova Scotia. This
14 particular event, the Desmond tragedy ... well, put it this way.
15 Obviously, an Inquiry can dig very deeply into the circumstances
16 of a particular event but it also takes time and resources. Do
17 you see this as the type of event or tragedy that would have
18 benefitted from an examination by a Domestic Violence Death
19 Review Committee?
20 **A.** Yes.
21 **Q.** Your final recommendation, and I guess this is sort of
22 where the rubber meets the road. A provincial implementation

1 committee. It's great to make recommendations, but they have to
2 be implemented. What's your thought on how a provincial
3 implementation committee would work and what would its value be?
4 **A.** I've been part of different inquiries and inquests and
5 major reviews by government on different issues related to
6 domestic violence and one of the things that I've noticed the
7 older I get is that there's a lot of interest and enthusiasm
8 about recommendations that are made but they get lost over time.
9 They get lost in a variety of ways that some of the
10 implementation, you know, may take a lot of time and patience,
11 and some may require investments, you know, and tax dollars and
12 so sometimes people move on and good recommendations are lost.
13 So my view, and again, I don't want to overstep my role as
14 an expert here, but my view is that this Fatality Inquiry has
15 been so comprehensive and thorough. There's so much information
16 that's been analyzed that I think it would be very sad to have
17 this lost with the passage of time.
18 So I would suggest that a potential recommendation for
19 Justice Zimmer to consider is an implementation committee which
20 would be made up of, you know, senior members of different
21 government ministries at the level of deputy minister to make
22 sure that the recommendations made are actually implemented and

1 by that is to both monitor and review the recommendations, to do
2 audits, to make sure, as you say, that the rubber actually does
3 hit the road and these things are taking place.
4 And part of the audit is to make sure that if there's some
5 really helpful recommendations they're not just taking place in
6 one or two communities, that they're actually happening across
7 the province in both rural and urban areas of the province. And
8 I'd suggest that this happen over a five-year period because I
9 think nothing happens overnight. None of the recommendations
10 that this Fatality Inquiry will suggest will happen overnight.
11 You can't flip a switch. Some of these things are very complex.
12 When you're talking about training and sharing information
13 and better information systems, they're going to take time. So,
14 therefore, I think a minimum five-year period to ensure that
15 things actually take place. So that's sort of in a nutshell
16 what I would envision.
17 **Q.** Have you seen provincial implementation committees in
18 other inquests or inquiries?
19 **A.** They're not a regular part. We have had ... I've been
20 part of other ... I was part of a committee in Ontario. This
21 goes back 20 years. We had a implementation committee looking
22 at some of the recommendations that came out of May-Iles Inquest

1 where we had community partners working actively with
2 government, and I think that was effective.
3 Actually, we had a judge who left the Bench for a year.
4 Actually, Justice Lesley Baldwin, Ontario Court of Justice, who
5 left the Bench to chair the committee, and one of the innovative
6 things in that committee was it was government and community
7 partners. Because sometimes the community can hold government's
8 feet to the fire, so to speak, if that's an expression used in
9 Nova Scotia, where the government may be more limited. But the
10 community can talk about what's actually happening in the field,
11 you know, that there may be a good idea, a good policy, but it
12 actually hasn't reached the field and it's not really being
13 implemented. It's not being used widely.
14 Sometimes it's ... implementation committee, the one I'm
15 referring to, we had community partners and we had more active
16 dialogues on what's happening in theory and what's happening in
17 practice. Because sometimes there's a giant gap between theory
18 and practice. Somebody can say, Yeah, we have that policy, but
19 nobody is actually using it. Nobody knows it exists.
20 **Q.** Thank you. Doctor, obviously, you can tell we're
21 coming to the end of your direct evidence. I want to thank you
22 for spending the time with me over the last day and a half

1 walking me through this and for the report that you provided.
2 There will be obviously cross-examination. But in conclusion
3 are there thoughts, anything that we haven't covered, something
4 that you feel is important for us to take away from this?
5 **A.** I think the report and I think the questions you've
6 asked me, I think I've been able to answer everything.
7 I want to say that this is a time ... I mean these
8 situations are horrible. Over my career I've reviewed over 500
9 domestic homicides, and probably a third of them homicide-
10 suicides, some with multiple fatalities, and it doesn't get any
11 easier. And I think it's very painful. So I just want to say
12 for the record that my heart goes out to the surviving family
13 members and I never want them lost in this process and what
14 they've lost and what they've suffered and the lives that have
15 been lost.
16 And I also always think about the professionals who ... and
17 I know Justice Zimmer, from reading the transcripts, has been
18 reassuring to many of the witnesses that I'm sure many look back
19 and may have second-guessed themselves or wished they had said
20 or done something differently.
21 So I also want to make sure that in giving my evidence that
22 it's not a blaming or shaming exercise and I also think about

1 professionals and the work they do. They do their very best and
2 sometimes they're dealing with tragic outcomes. And so I'm not
3 into ... I don't intend to come across as shaming or blaming.
4 Just with that, my approach ... the reason why I'm still at
5 this work after 40-plus years and why I'm not depressed or
6 retired, when my kids ask me, you know, Dad, how do you do this
7 work, or, Why do you do this work? And my analogy to them is
8 always I feel like I'm looking for the black box after an
9 airplane crash. You know, I can't bring back the passengers,
10 but I'll be damn sure that other passengers are not going to go
11 through the same thing; that if there's pilot error, you know,
12 if there's a problem with the aircraft manufacturer, if there's
13 a problem with a runway being too short or no one's had training
14 in flying in freezing rain, I'm going to make sure that everyone
15 knows about that so we're going to keep future passengers safe.
16 So that's my analogy for the work I do. So in writing the
17 report my focus is learning from the past, but my focus is on
18 the future. You know, how can we prevent a tragedy in similar
19 circumstances in the future? Because there will be certainly
20 many victims of domestic violence who are thinking about, you
21 know, Should I call the police, is there help for me, where do I
22 ... and I think we like to reassure people that we're always

1 working on improving our responses in the community.

2 So those are the only other comments I thought of.

3 **Q.** Thank you very much, Doctor.

4 **THE COURT:** Thank you. Thank you, Mr. Murray. Thank

5 you, Dr. Jaffe.

6 We're at a point I think where we'll break for lunch. It's

7 20 after 12 here. We'll break for approximately an hour, come

8 back at 1:30 our time. I guess that will be 12:30 your time.

9 **A.** Yes, Your Honour.

10 **THE COURT:** That a convenient time for you? All right.

11 Thank you. We'll break for lunch. Thank you.

12 **COURT RECESSED (12:21 hrs.)**

13 **COURT RESUMED (13:32 hrs.)**

14 **THE COURT:** Thank you. Ms. Ward?

15 **MS. WARD:** Ms. Grant has some questions.

16 **THE COURT:** Ms. Grant?

17

18 **CROSS-EXAMINATION BY MS. GRANT**

19

20 **MS. GRANT:** Thank you, Your Honour. Good afternoon, Dr.

21 Jaffe. My name is Melissa Grant. Hi.

22 **A.** Good afternoon.

1 **Q.** Good afternoon, sorry. Got to get used to the delay
2 and the caffeine I just had for lunch. I am representing the
3 Attorney General of Canada and the various federal entities that
4 are involved in the Inquiry. Thanks very much for being here.
5 We've learned a lot and I think your observations have been
6 invaluable to the Inquiry.
7 A comment that you made earlier before the break where you
8 said that, in your experience, the federal government has
9 listened with, I think you said" both ears open". I can assure
10 you that there are many ears listening and your observations
11 will be shared, of course, with our clients.
12 On that point, I think one of the things that you said
13 earlier about this not being a blaming and shaming exercise;
14 but, rather, a way to prevent tragedies in the future, I think
15 that is really important to hear because we've heard from some
16 of the frontline workers, the case managers, have been very
17 deeply impacted by this tragedy and the feeling that people
18 think that they don't care about the veterans they serve, and so
19 I just want to thank you for making those comments. I think
20 they're really helpful for the broader audience that are
21 listening.
22 A question about terminology in your report. In your

1 report, if we can pull it up if it's available, Exhibit 334, you
2 note in some of your footnotes, you use the terms "domestic
3 violence" and "intimate partner violence" interchangeably.
4 That's right?
5 **A.** Yes. Yes.
6 **Q.** And at footnote number 2 of your report which is on
7 page 3, you also indicate, you use the term "femicide", and I
8 just wanted you to comment on that and whether, in your view,
9 that these events do meet the definition of a femicide and why
10 that is.
11 **A.** Well, the term "femicide" is a broader term that
12 refers to killing of women and girls, in particular, in a
13 variety of contexts; so, to the extent of which, in this case,
14 an intimate partner, who is a woman, is killed, certainly fits
15 the definition of "femicide". I'm not sure it's really a lot
16 more complicated than that. I mean I think the term "femicide"
17 tends to be used by a number of researchers just because of the
18 disproportionate number of women that are killed by men.
19 Obviously, men are in danger of other men and women are most in
20 danger of men in a variety of contexts. So I think it fits the
21 definition.
22 **Q.** Thank you. I just want to turn to a couple of

1 different aspects of your report. So on the issue of firearms,
2 just a couple of points from looking at your testimony from
3 yesterday and then your report as well. So yesterday you had
4 indicated that you couldn't locate any public information on who
5 to call if you had concerns about firearms. If I'm getting that
6 wrong, correct me.
7 **A.** Yes, I did a Google search about reporting concerns
8 about someone's use of a firearm and I couldn't find anything
9 online, either provincially or federally.
10 **Q.** Okay. So in the context of this Inquiry and it being,
11 you know, an opportunity to educate people as well, I googled "I
12 have concerns about firearms", and the information that comes up
13 is something that we've actually talked about at the Inquiry
14 through previous witnesses, including the firearms officers of
15 New Brunswick and Nova Scotia. So there is a 1-800 number.
16 It's 1-800-731-4000. And I'm just repeating that, for the
17 benefit of the people that may be listening in, that that
18 connects you to the Canadian Firearms Program and it is a number
19 where you can share concerns if someone has a firearm. And,
20 again, it's the Canadian Firearms Program, and the Canadian
21 Firearms Program has a website as well that talks about that and
22 concerns.

1 So I just kind of wanted to put that out there just because
2 there is a number that people can call that's sort of beside the
3 911 if it's not an emergency because, you know, people are
4 taught not to call 911 unless it's an emergency. So general
5 concerns can be brought to that number, so I just wanted to kind
6 of raise that on the record.
7 The other aspect about firearms that I wanted to talk with
8 you about is a note in your report on page 17 that said that, as
9 a CAF member, Lionel Desmond had "ready access to firearms".
10 And I just wanted to talk about that a bit because from our
11 understanding from our CAF client is that that's not correct,
12 that firearms are actually highly controlled. Unless you're
13 deployed in the military theatre, you wouldn't have an issued
14 firearm. So do you have any particular evidence about that? Or
15 if I told you that firearms within CAF are kept in a vault and
16 they're disassembled, and if somebody is in, like Lionel Desmond
17 was, a transition unit where he wasn't able to possess firearms
18 that, in fact, a CAF member does not have ready access to
19 firearms in their personal life?
20 **(13:40)**
21 **A.** I think that's important to have on the record. I
22 think it might've been a poor choice of words on my part, I

1 think, but my assumption is a more general assumption. When I
2 work with people in the military or police officers, because of
3 the nature of their profession, they're more knowledgeable about
4 firearms, they have more interest, they have more sources to
5 gain firearms, so I think I could've worded that better. I
6 wasn't saying that was on the ... you know, that wasn't specific
7 access through the military, so I could've worded that better.
8 I think it's a good point. Thank you.
9 **Q.** Thank you very much. Yeah, I think the really only
10 point is that for people who are police or military veterans,
11 that a weapon for their personal use is through the Canadian
12 Firearms Program that's provincially administered in Nova
13 Scotia. I think that's the clarity there. Thank you.
14 I just wanted to turn to one point of clarification, and I
15 would really say it's a minor point in your report and it's a
16 point that I'm confident that Inquiry counsel and Judge Zimmer
17 are aware of but, given that we have a broader audience, I just
18 wanted to clarify. At pages 22 and 23 of your report, you refer
19 to Ms. Zandra Pinette as a VAC social worker or a CAF social
20 worker, and our information is that she was essentially an EAP
21 counsellor, so she's an independent contractor and not an
22 employee of VAC or CAF. So if I put that to you, do you have

1 any evidence to the contrary on that point?

2 **A.** No. She was described as such in the notes of

3 somebody else. I might've used the same terminology that was in

4 the Child Protection file, but I have no independent knowledge,

5 so I have no disagreement with you, if that's the fact.

6 **Q.** Okay, thank you.

7 **THE COURT:** She reported back to somebody at Department

8 of National Defence.

9 **MS. GRANT:** Right.

10 **THE COURT:** Am I correct? She wasn't employed by them

11 but she reported back to them.

12 **MS. GRANT:** She would never have, no.

13 **THE COURT:** No? All right, go ahead.

14 **MS. GRANT:** And another point about, talking about risk,

15 it's been, obviously, a topic of discussion in the last two

16 days; a really important topic of discussion. In your report at

17 page 22, you talk about the CAF and the VAC tools that were used

18 to note a moderate, and then, subsequently, a high risk for an

19 unsuccessful transition. Do you recall those?

20 **A.** Yes.

21 **Q.** I'm mindful, in our discussion about this point, about

22 all the things that you noted in terms of things that we've all

1 seen as maybe red flags that weren't noted as such at the time
2 by many people involved in the case but I just wanted to make
3 the point that that tool was not designed to assess risk for
4 violence.
5 **A.** Yes, and I think I certainly meant to testify to that
6 or write, because I think, in looking at the tool, it's clearly,
7 it's designed more to how a veteran is going to, you know,
8 adjust back to civilian life, and it's certainly high risk in
9 terms of a potential poor adjustment, but it doesn't relate to
10 domestic violence, per se.
11 **Q.** Thank you. And, again, in asking these questions, I'm
12 certainly mindful of the recommendations and the basis for those
13 and the opportunities for improvement. One of the things that I
14 think is a struggle in this case is kind of the concept of
15 personal autonomy and how that concept interacts with medical
16 professionals, with police, with everybody. And if we're
17 looking at how we would implement those recommendations, it's an
18 important element of the discussion, but you do note in your
19 report that calling the police was a needed act. And, I guess,
20 in your discussion about the police interventions, things like
21 the concerning text messages that you discussed with Mr. Murray
22 earlier, "I've got eyes on a .22 Magnum", a threat to kill

1 everybody, those were never brought to the police.
2 And so I guess my question is, other than all the things
3 that we're talking about doing in terms of recommendations, how
4 do we, you know, get people to maybe report that to the police
5 so that they can take action? And maybe that's a big question
6 but it's certainly something we're discussing.
7 **A.** I think it would be part of my recommendation 1 and 2
8 so, obviously, it gets to the issue of public education because,
9 obviously, to the extent to which, you know, a victim is dealing
10 with some extreme circumstances and being uncertain about coming
11 forward, the extent to which, you know, she shares that with
12 family members or, potentially, friends. So the frontline is
13 always friends and family and coworkers and the other thing is
14 more professional education. You know, it could be an
15 interview.
16 This comes back to the discussion I had with Mr. Murray and
17 evidence about reluctant victims, you know, many victims are
18 reluctant/ambivalent. So I think a police officer intervening,
19 for example, when there's the call about potential suicide, or
20 when Lionel Desmond talks about going to the garage, there's an
21 opportunity, when the police intervene, to say, I know you're
22 worried about your husband, you know, have you ever worried

1 about your own safety, you know, has he said things? So I think
2 there's an opportunity to do that.
3 And, again, I do a lot of training with police and there's
4 - with any profession, whether you're a psychologist or a police
5 officer, there's many approaches to the work. Some of it is
6 just sort of, Just the facts, ma'am. Like, just keep it brief
7 and keep it simple, you know, you only have a short time for the
8 intervention. Or there's a time when you might sit down and
9 say, you know, I'm worried about you, you know.
10 Obviously, I think your point is important; just don't
11 think the autonomy. The victims have to decide who they're
12 going to tell what and when, and that's their right, but I think
13 sometimes, they can be encouraged or engaged when they're living
14 with difficult circumstances. So I think it's a balancing act.
15 I mean the bottom line, to me, is educating the general
16 public and then obviously educating professionals to engage men
17 and women involved in issues around domestic violence.
18 **Q.** Just a couple of other points.
19 One of the things you mentioned in the report was kind of
20 like this idea that Lionel Desmond might've been considering
21 bankruptcy and that sort of thing; there were financial issues,
22 and, obviously, a lot of that focused on his beliefs about his

1 wife's spending as opposed to his own spending, but the Inquiry
2 did hear evidence from VAC, a Veterans Affairs Canada
3 representative, who set out the various benefits and pensions
4 that Lionel Desmond had been receiving. And so do you have any
5 particular comments about the financial situation or were you
6 sort of just basing your comments on, you know, what he
7 reported?
8 **A.** I'm basing it on what he reported. I mean he seemed
9 concerned about having nowhere to go and not having funds and
10 not even, you know, being able to afford a gym membership. So
11 that was a repeated theme. I did note something of interest. I
12 think it was in Ste. Anne's. I think a psychologist or social
13 worker noted the disparity between what Lionel Desmond thought
14 about his finances and what his wife said was the reality. So
15 he seemed to have ... and there's reference. The general thing
16 I remember is that, in fact, he was reading some of the
17 financial statements wrong, that there was some statements he
18 read that made him think he owed more money than he did. So I
19 noted that. So, clearly, there's an issue with a factual basis
20 for what he's reporting versus the perception and his concern,
21 which is certainly worrisome.
22 **(13:50)**

1 **Q.** In your own experience, where you've been doing this
2 work for a long time and just turning to another topic, and I
3 understand you're in London, Ontario, how long would it take,
4 typically, in London to obtain a full neuropsychological
5 assessment for somebody?
6 **A.** It would take time. I couldn't give you a definite
7 answer. I mean I would say, if I had to pull a number out of
8 the air, I'd say three to six months, and you might have to
9 annoy and harass the neuropsychologist to be seen. So I think
10 it would also be an issue of trying to prioritize the case,
11 depending on the circumstances, so I think I would say that
12 neuropsychologists are in short supply across the country and I
13 think it's fair to say that waiting lists may vary.
14 **Q.** Okay. And I know it would be unfair of me to ask you
15 about Nova Scotia because you're not in Nova Scotia, so that's
16 why I kind of picked where you are as an example.
17 I guess this is a harder question, I guess, in terms of the
18 big picture, and I think that we're in a situation where a lot
19 of people saw a lot of trees, but not a lot of people saw the
20 forest, you know, to use sort of a metaphor that most people are
21 familiar with. And one of the things that you said yesterday
22 kind of struck me, which is that you said, in your line of work,

1 people continue to express shock when these kinds of things
2 happen, but that they're not shocking from a research
3 perspective. And I guess that kind of dovetails into, you know,
4 I just kind of want your comments on this, the issue of what you
5 said earlier which is that most people with PTSD are not
6 violent.
7 What would you say, I guess, to the people who are
8 veterans, families of veterans, who are kind of sitting at home
9 and don't have the other risk factors that we see in this case
10 and they're worried that this is going to happen to their
11 family? What can you offer them? And while you're thinking
12 about that, I will preface it with, you know, I know you're in
13 Ontario, but here in Nova Scotia, there has been a sort of
14 narrative, not in this courtroom but outside, perhaps, that PTSD
15 equals this tragedy.
16 **A.** Well, that would be a terrible conclusion and would be
17 inappropriate. I think there are lots of people who have PTSD
18 and many veterans who have PTSD and they never harm anyone. So
19 PTSD doesn't mean you're going to be violent, doesn't mean
20 you're going to be abusive to your wife. So the general
21 conclusion from PTSD is you have a mental health problem and you
22 need help and support from medical professionals and support

1 from your family to understand what you're going through, but
2 you're not a danger to them or anyone else, you know, period.
3 What I meant to testify to is more the more narrow
4 situations where somebody has PTSD and they're going through a
5 separation and there's a long-term history of domestic violence
6 and severe conflicts. And we're, like in this situation, we're
7 dealing with at least 20 risk factors. So we're dealing with
8 exceptional circumstances. So this would not apply to the
9 average veteran.
10 And I appreciate your questions are critical because it
11 reminds me that my testimony, your questions, and my answers are
12 being livestreamed, and so people are taking in the information.
13 That's a good reminder for me because I think, in reality, we're
14 moving in a totally different direction. I work, in my work,
15 both military, I work a lot with police. There's a lot more
16 recognition about understanding PTSD and getting people help and
17 not providing stigma, especially for military employees. I put
18 them in a similar category because they're both male-dominated
19 professions where, you know, they're sort of the extreme of our
20 stereotype of Canadian men where we're strong and tough, we
21 don't need help, you know, we don't even ask for directions let
22 alone seek advice of a psychologist or therapist. So we're

1 trying to change that. And, certainly, my best advice is people
2 need to reach out for help. This is a very important area but I
3 wouldn't connect it in any way in general to domestic violence.
4 It puts you at an additional risk.
5 **Q.** Thank you, Dr. Jaffe, and thank you for being such a
6 strong voice on this really important issue. Those are all my
7 questions.
8 **A.** Thank you.
9 **THE COURT:** Thank you, Ms. Grant. Mr. Anderson or Ms.
10 Lunn?
11 **MR. ANDERSON:** No questions. Thank you, Your Honour.
12 **THE COURT:** All right, thank you. Mr. Macdonald or Mr.
13 Morehouse?
14 **MR. MACDONALD:** Thank you, Your Honour.
15
16 **CROSS-EXAMINATION BY MR. MACDONALD**
17 **(13:56)**
18 **MR. MACDONALD:** Good afternoon, Dr. Jaffe. My name is Tom
19 Macdonald. I am the lawyer for the Borden family, so they would
20 be the mother, father, brother of Shanna Desmond; the
21 grandparents of Aaliyah; and the brother and uncle of Shanna and
22 Aaliyah. And I'm co-counsel for Aaliyah, for lack of a better

1 word, with Tara Miller who is also here today.
2 I wanted to go to a few comments in your report and really
3 just by overview. So if you would bear with me, we'll do that.
4 I don't know that you need to turn to a specific page, Dr.
5 Jaffe, but, of course, you can if you need to. So I'm going to
6 summarize.
7 There is a portion in your report that deals with warning
8 signs from professionals, and you'll remember you mentioned that
9 about 40 professionals had interacted with Mr. Desmond. And you
10 have a sentence here, and I'm reading, verbatim, your sentence:
11 It was shocking that any professional would
12 think he should have a firearm license in
13 the context of all the available information
14 about the risks he presented.
15 Do you remember that sentence from your report?
16 **A.** Yes.
17 **Q.** Can you expand on that for me, please?
18 **THE COURT:** Mr. Macdonald, do you have a page reference?
19 **MR. MACDONALD:** I do, Your Honour, it's page 21.
20 **THE COURT:** Thank you.
21 **MR. MACDONALD:** And, of course, it's Exhibit 334.
22 **THE COURT:** Thank you.

1 **A.** It would be helpful to pull it up just to make sure
2 that ...
3 **MR. MACDONALD:** Of course.
4 **THE COURT:** We'll put it up right now.
5 **MR. MACDONALD:** And, Dr. Jaffe, when it's up, it's page 21
6 under the heading "Warning Signs from Professionals" and that
7 sentence begins about nine or ten lines down.
8 **A.** Right. I think, in writing that, there were so many
9 concerns on the file about Lionel Desmond's mental health; about
10 his PTSD; about being depressed; about being suicidal; that it
11 would be shocking that he would have a firearm license or
12 anybody would approve that. I mean I think the sentence is
13 self-explanatory just in the sense that he would be one of the
14 first ... If there's ever going to be somebody that you would
15 not want to have a firearm, it would be Lionel Desmond in these
16 circumstances, given what he's going through in his marriage and
17 given what he's struggling with with his mental health. I mean
18 not only wouldn't he have a license, but I think my testimony
19 earlier today was I would hope that every medical professional
20 who saw him, whether it's a mental health professional or
21 frontline physician, would advise him to stay away from firearms
22 to and have any removed.

1 **(14:00)**
2 **Q.** And would your comments, I don't want to put words in
3 your mouth, but would they also apply to those folks who would
4 be responsible for reinstating a firearms license; government
5 officials?
6 **A.** Yes. I mean I don't ... You know, in looking at the
7 history, when there's issues documented since 2011, looking at
8 the history, there would be no point in time where someone would
9 say, Well, everything is fine now. There was ongoing concerns
10 and struggles for some time, so I would obviously be concerned
11 about him having access to firearms because it just creates so
12 much risk about suicide and it creates risk also about homicide
13 and it's something that I think could be explained to him in a
14 pretty straightforward fashion.
15 **Q.** At page 23 of your report, there's a section that
16 deals with "Risk Factors from Review of Inquiry Evidence", and
17 I'm focusing on the portion that speaks to, I'm paraphrasing,
18 Shanna seldom or ever being interviewed alone to get Shanna's
19 perspective, if I can put it that way. You're familiar with
20 what I'm thinking about here?
21 **A.** Yes. Yes.
22 **Q.** I know you've expanded on it, but can we go back to

1 that for a moment and can you think of potential reasons why
2 separate, discreet interviewing of Shanna would not have taken
3 place, whether it was ... you know, what would cause
4 professionals to perhaps, you know, inadvertently overlook that
5 or not go there?
6 **A.** Well, a couple of things. I think sometimes
7 professionals are focused on who their client or patient is. So
8 to the extent that someone is treating, you know, Cpl. Desmond,
9 they're focused on him and his mental health and his well-being,
10 and family members sometimes may be seen as an important
11 collateral source of information, but they're not seen as a
12 separate individual with their own needs and potentially facing
13 their own risks in these circumstances. So I think sometimes
14 it's sort of a more narrow focus; and sometimes it could be
15 related to time; and sometimes it could be related to not
16 wanting to put someone on the spot at that time, but it would, I
17 think, require somebody to be able to say to Shanna, I think, as
18 I said, earlier, I'd like to talk to you. I know this has been
19 a very difficult time for you and I'd like to have a chance to
20 touch base with you. So I would encourage that.
21 For example, and there are many, you know, generally, when
22 I look back at these tragedies, there's many turning points or

1 missed opportunities, but there's some that seem more obvious
2 than others. There's a point at which Shanna and Lionel, and
3 again, I'm informally calling them by their first name which
4 means no disrespect but there's a time when I think he's ready
5 to leave Ste. Anne's and they can't hold it together in the
6 discussion between the two of them. And that would be a time
7 when I think it might've been important to talk to her alone
8 about how she was coping and struggling. There was times when
9 she was at the hospital.
10 One of the things I noted from the file that she, being a
11 nurse and being a spouse, she seemed to be looking for answers
12 and trying to find ways to manage the situation, and so she had
13 a lot of pressure. She was a caregiver and caretaker. And that
14 might've been another opportunity to have time alone with her
15 about how she was coping and dealing with it. So I think those
16 are potentially, looking back, those are potentially missed
17 opportunities.
18 Actually, this is an aside, but it relates to your
19 question. In Ontario, we have domestic violence programs that
20 try to provide an intervention for men who abuse and they're
21 called "Partner Assault Programs", and they're
22 psychoeducational. They're usually, you know, 12 weeks or more.

1 They may vary. So it's usually group counselling for men,
2 trying to get them to think about, you know, their behaviour and
3 the impact it's having on their partner and on their children.
4 As part of that program, what's built in is that there's a
5 contact with the spouse. So there's another person assigned to
6 have regular contact with the victim or spouse, and the reason
7 for that is you don't someone going to treatment and saying,
8 Everything is fine, you know, there's no problems here; in fact,
9 you need independent support and counselling for the victim in
10 the circumstance to get a report about how someone is changing,
11 because if someone is just going to group and spinning a story
12 how everything is better or it's not that bad, you want to make
13 sure there's, you know, independent contact with the spouse to
14 have some reassurance on the changes that are taking place. You
15 don't want, for example, someone to stop being physically
16 abusive but they're getting more emotionally and psychologically
17 abusive.
18 Anyways, I mention that example just to emphasize that the
19 recognition of contact with the spouse is so critical, it's
20 actually built into batterer intervention programs.
21 **Q.** Thank you. At page 33 under Recommendation 4, you
22 have a reference to Aaliyah's safety and the concerns raised,

1 and it reads "related to the maternal grandfather". You're
2 familiar with what I'm speaking of, I think?
3 **A.** Yes.
4 **Q.** Yes. And now, since you wrote this report, I
5 understand from Inquiry counsel, Mr. Murray, I think I have it
6 right, you've had occasion to read Exhibit 346 which is the
7 affidavit of Brian Malloy from Department of Community Services?
8 **A.** Yes, I have.
9 **Q.** Right. And you'd agree with me, Dr. Jaffe, that the
10 allegations that triggered the phone call to Community Services,
11 they were communicated from Lionel Desmond to his therapist, who
12 then communicated them to DCS, right?
13 **A.** That's correct.
14 **Q.** And you'd also agree with me that in Mr. Malloy's
15 affidavit, there's no evidence that those allegations ever
16 contained sexual or physical misconduct components, did they?
17 **A.** No, that's not what the record shows, that's correct.
18 **Q.** And you'd also agree with me that, according to Mr.
19 Malloy, there was no indication of any risk to the child and no
20 action was required. Correct?
21 **A.** That was his view of the circumstance.
22 **Q.** And just to finish off this point, Doctor, and you

DR. PETER JAFFE, Cross-Examination by Mr. Macdonald

1 have read the affidavit of Mr. Malloy. One of the allegations
2 communicated by the therapist was that she, the therapist, was
3 in disagreement with the Borden family's concern that Cpl.
4 Desmond was unstable. Do you remember that reference in the
5 affidavit?
6 **A.** Yes, I do.
7 **Q.** And that was in November of 2015, and we have the
8 benefit of hindsight. So you'd agree with me that about 13
9 months later, on January 3rd, 2017, horrors of horrors happened
10 where the Borden's concerns were unfortunately realized because
11 Cpl. Desmond killed their daughter and granddaughter. Correct?
12 **A.** Yes.
13 **Q.** I want to move on to another topic that you, in
14 response to a question by Mr. Murray this morning, towards the
15 end of your examination, you indicated you didn't, and I'm
16 paraphrasing you, Doctor, but you didn't want the surviving
17 family members lost in the process?
18 **A.** That's correct.
19 **Q.** Yes. Can you expand on that? What does that look
20 like to you; in other words, those left behind not being lost?
21 **A.** Well, to me, it means ongoing counselling and support
22 because, you know, they've dealt with the worst possible of all

1 circumstances you can imagine a family going through. And not
2 only did they go through it in 2017, but they have to revisit
3 it. I mean such is the nature of court proceedings or
4 inquiries, so it's something that remains in the media, you
5 know, with various pieces of information, so their private lives
6 have been laid wide open. So a starting point for me is a
7 chance for them to debrief, to receive ongoing support through
8 appropriate counselling. That would be a starting point.
9 I think sometimes families ... when I said families get
10 lost, what I mean by that, sometimes, and this is my experience
11 in criminal proceedings as well, sometimes there's a lot of
12 attention and then everything suddenly ends, but the family is
13 left to pick up the pieces and carry on with their lives. And I
14 just think it's very painful and very difficult.
15 **(14:10)**
16 **Q.** Would support, to you, include a possibility of
17 financial support or government assistance to move on with life
18 for those surviving family members?
19 **A.** If I can answer that question, seeing no objections, I
20 would say financial support may be part of what's needed because
21 sometimes, for example, if you're ... and, again, I can't speak
22 to the availability of counsellors. Sometimes, you know, to get

1 counsellors on a longer-term basis, it may be more on a fee-for-
2 service basis. So having access to resources that allow you to
3 ... access to financial support that allow you to access help on
4 a more timely and long-term basis, I think that would be
5 critical.
6 I can say generally, in my experience in Ontario, when
7 parents have lost a daughter to domestic violence, aside from
8 their own ... part of their own grief and recovery is seeing
9 benefits to others in the future. That's part of making sense
10 of horrific tragedies. So, for example, I've seen families, you
11 know, wanting to create a, you know, a website or a school
12 curriculum or a special program in their daughter's name. I
13 don't know if that's too narrow, but I've seen that for a number
14 of families where they want some positive legacy often in their
15 daughter's name as part of either providing services ... perhaps
16 I'll give you an example if that's helpful.
17 **Q.** Sure, of course.
18 **A.** In Ontario, we had a child homicide. Parents fighting
19 over custody of a child and, eventually, the father, who had
20 been convicted of domestic violence, killed the child as an act
21 of revenge against the mother. And, in that case, the mother,
22 through the support of others, and compensation, was able to

1 develop a resource center in her son's name to help other
2 victims and children going through similar circumstances. So
3 that's a very concrete thing. So I'm using an example. In that
4 case, the mother was able to get access to resources that
5 created a positive legacy, and this mother was doing public
6 speaking to schools to, you know, judges, lawyers, across the
7 province, on her experience to hopefully educate others. And
8 I'm not sure if I'm going on too long with that example, but
9 that's an example of what people sometimes do with compensation.
10 **Q.** Thank you, Dr. Jaffe.
11 One of your recommendations deals with ... well, you have
12 eight recommendations and, of course, one of them deals with the
13 implementation committee, and I've heard you say that the deputy
14 minister level would be a helpful group of people to have on
15 there to ensure that those things are implemented and there's a
16 five-year plan. But are some of your recommendations ... I mean
17 if the will and the funding is there from government, in this
18 particular case, the Nova Scotia government, are some of those
19 recommendations capable of being implemented much earlier than
20 five years?
21 **A.** Yes. Again, without doing a detailed analysis. I
22 mean some are probably low-hanging fruit, so to speak, and some

1 things could be done more quickly. Some things take time.
2 There's actually, you know, some research from other
3 jurisdictions; for example, there's research out of Washington
4 State that talks about the time delay between governments
5 endorsing something as a good idea, to it actually getting
6 implemented. So some things are going to be more complicated
7 than others, you know, some of the training programs are going
8 to take, you know, time to develop and implement, making sure,
9 for example, so the recommendations about the different
10 professional bodies, making sure that social workers and
11 psychologists, psychiatrists, have proper knowledge about this.
12 Some of this is going to take time to implement.
13 So my short answer is some can be done right away. If your
14 question is, Do we have to wait for an implementation committee,
15 the answer is no, some things can be implemented right away, but
16 some are going to be more heavy lifting and, in fact, I would
17 predict you'd find some resistance from ... so it takes more
18 time and more accountability.
19 **Q.** Can you flag for me, of your eight recommendations,
20 which would, in your view, in your opinion, take the heavy
21 lifting and encounter resistance? Which of the eight?
22 **A.** I think some of the ones; for example, I think

1 Regulation 3 about police training. I mean some of that would
2 take more time. Especially, any recommendation I made which
3 also involves doing an audit to make sure not only are things
4 implemented, but people are actually following through and the
5 rubber is actually hitting the road. And I say that from many
6 years of experience where, I'm not saying Nova Scotia
7 government, but, in general governments may say, We're already
8 doing that; but, in fact, they're not. I mean they may be doing
9 it in the sense they've circulated a memo.
10 So sometimes we see cases where someone thinks something is
11 important and they just circulate a memo - From now on, we'll be
12 doing this. But just having a memo go out is not the same as
13 actually tracking whether it's actually happening in the field.
14 So those kinds ... any recommendations that deal with
15 accountability or audits are going to take more time. And I see
16 that in my work in terms of doing, for example, police training.
17 So there may be some directive, but it takes some time for, you
18 know, for everyone in the force to be, and the service to be,
19 trained.
20 And, for example, I used the example yesterday that, within
21 our jurisdiction, we have domestic violence coordinators who
22 review police occurrence reports to make sure they're not missed

1 opportunities to either do a risk assessment or provide more
2 follow-up services or red flag a certain case.
3 So I'm giving you sort of a long-winded answer to some
4 things definitely take more time. And just because somebody
5 tells you it's happening doesn't mean it really is.
6 **Q.** Understood. Thank you, Dr. Jaffe.
7 Finally, Dr. Jaffe, at page 27 of your report - that's the
8 "Conclusions and Recommendations" section you say, with the
9 benefit of hindsight, that what happened on January 3rd, 2017,
10 was predictable and preventable. Do you stand by that
11 conclusion today?
12 **A.** Very much so. That would still be my opinion today.
13 **Q.** Those are my questions, Your Honour. Thank you, Dr.
14 Jaffe, I appreciate it.
15 **THE COURT:** Thank you, Mr. Macdonald. Mr. Rogers?
16 **MR. ROGERS:** We have no questions, Your Honour.
17 **THE COURT:** All right, thank you. Ms. Miller?
18
19 **CROSS-EXAMINATION BY MS. MILLER**
20 **(14:19)**
21 **MS. MILLER:** Good afternoon, Dr. Jaffe. My name is Tara
22 Miller and I am counsel representing the personal representative

1 of Brenda Desmond, that's Cpl. Desmond's mom, and also, as my
2 friend, Mr. Macdonald, indicated, I share representation with
3 him through the personal representative of Aaliyah Desmond, Cpl.
4 Desmond's daughter. I just have a few follow-up questions
5 initially for you. You indicated that you had a book,
6 referenced a book, and I think it was yesterday, you said there
7 was a chapter in that book for specific groups and risks
8 presenting for those groups. What was the name of that book?
9 **(14:20)**
10 **A. Preventing Domestic Homicides: Lessons Learned from**
11 **Tragedies.**
12 **Q.** And when you said that there was a chapter in your
13 group for specific groups and risks presenting within them,
14 would there have been any consideration in that chapter to
15 African Canadian groups or veteran military groups?
16 **A.** Yes. Actually, the whole book is divided into
17 different chapters looking at different groups. So we deal with
18 issues about the challenge of individuals living in rural,
19 remote communities; the challenges of people in same-sex
20 relationships where they're experiencing domestic violence; and
21 we have a chapter dedicated to unique risks related to the
22 police and the military as two groups who are high risk for a

1 number of reasons. We have a chapter dedicated to immigrant and
2 racialized groups more broadly; obviously, not narrowed in on
3 African Nova Scotians, but more broadly. We have a chapter on
4 women who kill. We have a chapter on individuals suffering with
5 depression and mental health disorders connected to domestic
6 violence. I'm trying to think of the other chapters. If you
7 give me one moment, I have that handy.
8 **Q.** No, I wanted to get just a little bit of more ...
9 thank you for that, a little bit more information about the
10 specifics within the chapters.
11 **A.** Okay.
12 **Q.** And your reference to racialized groups and police and
13 military responds to the question I had about those specific ...
14 **A.** Right.
15 **Q.** So thank you.
16 **A.** Okay. The one reason we wrote the book ... There's
17 also a chapter about older couples and the one reason we wrote
18 the book is because domestic homicides, although there's a
19 common understanding, they're such diverse populations and there
20 are unique contexts in people's lives that have to be
21 considered.
22 **Q.** Thank you. Your report is very thorough and certainly

1 reviews all of the, or indicates the missed opportunities and
2 the warning flags, the red flags, that were raised with the
3 domestic violence behaviour that was chronicled throughout
4 records. But in your review, Dr. Jaffe, did you see any
5 evidence of domestic violence behaviour manifesting itself with
6 Cpl. Desmond before his PTSD diagnosis in September of 2011?
7 **A.** There was nothing that I found documented. I found
8 notes about the early relationships and reports from Shanna's
9 family about how they met and got married and had a baby but
10 there was no ... I didn't find any official record about abuse
11 that took place before he was deployed.
12 **Q.** Before he was deployed, and we know he was deployed
13 after Aaliyah's birth in 2007/2008, and his diagnosis of PTSD
14 was in 2011 but, in between that period of time after he was
15 deployed and before his diagnosis in September of 2011, is that
16 the same answer? No evidence of anything documenting domestic
17 violence behaviour up until that point?
18 **A.** Nothing that I can recall. If there's anything
19 different, I'd hope you alert my attention to it, but I read a
20 lot of documents and I don't recall anything.
21 **Q.** Thank you. One of the things I found, I think, and
22 you said, your group is very optimistic and hopeful. You

1 indicated yesterday, I'm going to just summarize as I understood
2 your evidence, that one in eight homicides are domestic violence
3 homicides and that you're very encouraged because those are the
4 most predictable and preventable of all homicides. And that's
5 not a controversial statement; I think that was your words, that
6 that's well-accepted and widespread. And if I can break that
7 down a little bit more, you said, It's highly predictable, it
8 doesn't have to have happened. And, you know, we look at missed
9 opportunities to intervene.

10 And in terms of being predictable, Dr. Jaffe, if I could
11 just kind of take you through a summary of those things that
12 you've indicated would allow us to predict. Predominantly, it
13 would be, I would assume, using the danger assessment risk tool
14 or domestic violence risk tool?

15 **A.** Yes.

16 **Q.** Yeah.

17 **A.** Or any risk tool that's been developed to deal with
18 domestic violence.

19 **Q.** Thank you. Yes, okay. And I think you said there was
20 about 2,000 of them but, you know, largely, 80 to 85 of them
21 overlap, and there were three ones that we reviewed here
22 yesterday.

1 **A.** Yes.
2 **Q.** Yeah, okay.
3 **A.** Actually, two dozen rather than 2,000 but go ahead.
4 **Q.** Oh. Thank you. I may have written that down wrong.
5 Thank you. So when you use that domestic violence risk tool, is
6 that used with the victim or is that applied with the
7 perpetrator?
8 **A.** It depends which tool. Let's talk about the danger
9 assessment tool. You'd be doing that with the victim. You'd be
10 sitting down with the victim and you'd get a narrative of their
11 life and their marriage and, you know, the most common forms of
12 abuse, the worst forms of abuse, then you'd be going through the
13 checklist as to which things they had experienced.
14 **Q.** Okay. So that would be with the victim, but are there
15 danger assessment or risk tools that are used also with,
16 potentially, the perpetrator, even if they haven't been charged
17 criminally?
18 **A.** Yes. You could use those same, some of those same
19 tools with the perpetrator; for example, the B-SAFER could be
20 ... you could address that, you know, directly with the
21 perpetrator. And, obviously, just yesterday when I testified, I
22 had talked about different contexts, so it's obviously different

1 if you're in a shelter seeing a woman for the first time who,
2 you know, comes to the shelter for safety and protection and
3 getting help compared to if you're in the correctional facility
4 and somebody has just appeared, you know, for intake and you're
5 trying to decide, you know, what institution they should go to
6 and the level of risk they may present, including a domestic
7 violence history, so you might use a different tool in that
8 circumstance.

9 If you're a police officer, you'd be doing the ODARA based
10 on the information you have at the scene and any, you know,
11 checks you might do on previous criminal history. So it depends
12 on the setting.

13 **Q.** So in terms of predictability, there would be risk
14 assessments that are for the victim; risk assessment tools that
15 can be used for the perpetrator; and then would it be fair to
16 say that there would almost be a third category, Dr. Jaffe, of
17 clinicians or treatment providers, those experienced in the
18 mental health world, using your own clinical judgement to almost
19 complete, as you've done, retrospectively, obviously, but
20 knowing what they know in the file, to complete their own
21 internal risk assessment?

22 **A.** Together with the tools.

1 **Q.** Together with the tools.
2 **A.** So I wouldn't ... right.
3 **Q.** Yeah.
4 **A.** And, again, it all depends on how much access to
5 information you have. My response yesterday, I mean, I always
6 contrast what a police officer is doing at the scene, trying to
7 assess risk, compared to, you know, forensic psychologists like
8 myself getting a referral from the court and having months to
9 review the file, you know, talk to ... you know, getting
10 collateral sources of information, getting school records. You
11 know, obviously, I can do a pretty comprehensive risk assessment
12 because I have access to multiple sources of information.
13 **Q.** Right. Sp when you have access to multiple sources of
14 information as a clinician or treatment provider, your ability
15 to predict domestic homicide is not restricted to a tool being
16 applied to the victim or to the perpetrator. There's a third
17 way that you could independently, as a clinician with the
18 appropriate information, address that yourself. Is that fair to
19 say?
20 **A.** Yes, obviously, yeah, the more information you have,
21 the better.
22 **Q.** Yeah. So if you have a victim that won't participate,

1 is reluctant, for a whole host of understandable reasons, or you
2 have a perpetrator who is not going to give up that information,
3 if you have the written record that contains information within
4 it, then that allows the clinician to assess on their own.
5 **A.** Are you referring to, for example, an exercise such as
6 this one, Fatality Inquiry, where all the information is
7 gathered and someone like myself looks at it after the fact, or
8 are you talking about a clinician being able to review a file?
9 I'm not ...
10 **(14:30)**
11 **Q.** I'm talking about sort of "in the moment". Sorry,
12 yes, appreciate the clarification, Dr. Jaffe. Not looking back,
13 as you are in terms of looking back to do a review, but in the
14 moment. So, for example, a clinician at Ste. Anne's ...
15 **A.** Yes.
16 **Q.** Who has access to the totality of his files, preparing
17 a discharge summary, you know, whether or not a risk assessment
18 had been applied with Shanna or with Cpl. Desmond during his
19 stay, that if that material existed within the information, that
20 it's still within the ability and the scope of a clinician to do
21 their own assessment.
22 **A.** Yes. I mean ... yes. So, again, there are different

1 contexts. Let me elaborate on that. I think, if you're worried
2 about somebody ... First of all, as professionals, I think we
3 have a responsibility, as mental health professionals, social
4 workers, psychologists, psychiatrists, if you think that's
5 someone at imminent risk of harm, you have an obligation to do
6 something about it whether people want help or not. So, I mean,
7 at some point although, in response to your colleague's question
8 earlier, you know, victim autonomy is central but, at some
9 point, victims lose their autonomy if there's an imminent risk
10 of harm; and, in particular, if there's children involved
11 because then it's not only just the adult safety. You're also
12 then thinking about third parties, you know, children.
13 So the answer is you still can form your own opinion and
14 act on those opinions depending on the context; certainly,
15 reporting to Child Protection. For example, this is an example
16 I gave earlier today, you know, if a police officer gets called
17 to a domestic violence scene and furniture is turned upsidedown
18 and somebody is bleeding and the neighbours have heard
19 screaming, if the woman, the victim, a mother, says, I don't
20 need any help from the police, and the man, let's say he's the
21 perpetrator says, I don't need you to be here; everything is
22 fine, the police officer would have independent responsibility

1 to contact Child Protection and be worried about the safety of
2 the children in those circumstances whether the parents are
3 cooperative or not. So just taking that as a very concrete
4 example.
5 And I'll just take one other example and I don't want to
6 ... My kids tell me I'm long-winded, so I don't want to be a
7 long-winded witness, but another example. If somebody is
8 discharged early, I'll take the Ste. Anne's example. Somebody
9 is leaving a stabilization unit, but they're not stabilized, you
10 know, they're leaving angry, upset, agitated. You've heard them
11 fighting, arguing, with their partner; they're not sure where
12 they're going to stay. They're going into a rural community
13 where they might not have supports in place. You may want to
14 red flag that case and you may want to do follow-up.
15 So if somebody says to you ... For example, if Lionel
16 Desmond leaves that hospital and says, I don't need your help
17 anymore; I'm fine on my own, you can say, I know you feel that
18 way but I'm going to follow up with you. And you can follow up
19 24 hours later or seven days later just to say, You know,
20 Lionel, I'm concerned about you. I'm concerned the state you
21 were in when you left. I'm concerned about you didn't know
22 where you were going to live. You were arguing with your wife.

1 I'm just checking in. I want to make sure you have supports for
2 yourself. In those circumstances, often, there's a
3 favourable response because it's ... So I'm not talking about,
4 you know, being intrusive in someone's life, I'm talking about
5 being a respectful, caring professional where you're worried
6 about somebody's safety and well-being. So I do think follow-up
7 is appropriate.
8 And this may go beyond your question, but I noted in the
9 file, although we have stereotypes often of military men who are
10 strong and silent and don't want help, I think Lionel Desmond
11 was one who was the opposite. He was desperately seeking help
12 from as many places as he could, including going back, you know,
13 trying to find records and getting access to records. So if
14 there's any resistance, it certainly wasn't ongoing resistance.
15 There might've been a time he didn't want people helping him
16 but, over the years, there's a pattern of him reaching out
17 repeatedly for help.
18 **Q.** Thank you. And just to finish off on the
19 predictability and preventability, the preventability comes
20 after those tools have been administered and things have been
21 flagged and then that is, if I understand your evidence, Dr.
22 Jaffe, the preventability is following up with the individual,

1 the perpetrator, with the victim. It's making sure there's warm
2 handoffs. It's a collection of different things that would be
3 part of the prevention moving forward. Is that fair to say?
4 **A**. Yes. And it's also ongoing.
5 **Q**. Yes.
6 **A**. So I think your question is a very important one
7 because a risk assessment is only good at one point in time.
8 For example, you might do a risk assessment in January; and,
9 obviously, if you have a high-risk situation, you want to be
10 able to review it in March or April to see if the circumstances
11 have changed.
12 One of the points that I think is critical is that a risk
13 assessment can never be an end in itself. You don't do a risk
14 assessment and then say to the victim, you know, Good luck.
15 Your life is in danger. Basically, you have to say, Your life
16 is in danger and here's what we need to do in terms of safety
17 planning for you and here's what we have to do in terms of risk
18 management, you know, for your partner.
19 A very important point that comes out of your question is
20 most perpetrators of domestic violence are not dangerous now and
21 forever. You know, domestic violence is something that is ...
22 where interventions are possible. I mean, clearly, there's

1 extreme cases where somebody is a psychopath. They don't care
2 about ... you know, they belong to organized crime and they
3 don't really care about any consequences. Most men who kill
4 don't want to be at that point in time, and, in fact, there
5 needs to be ongoing outreach.
6 So, in Lionel Desmond's case, he might've been designated
7 as very high risk. I'm just picking a month randomly and, you
8 know, January of the month. If, by April, he's got ongoing
9 counselling on a weekly basis, you know, he's joined a gym or a
10 health club, you know, somebody has found part-time work for him
11 that's meaningful, there's some counselling going on for him and
12 Shanna in terms of either separating or staying together and
13 trying to find a way to do that safely rather than the sort of
14 back and forth and uncertainty and where they are going to have
15 to give clear messages to each other on what's happening. If
16 those things are dealt with, you might come back and do a risk
17 assessment months later and the level of risk may have changed.
18 So my important point in there is risk has to be done on an
19 ongoing basis.
20 **Q.** Thank you. And I guess that brings us back full
21 circle to when I started with, you know, your comment yesterday
22 that domestic homicide is the most predictable and preventable

1 of homicides because if you do these things, predict it and then
2 work on prevention regularly, you can make a meaningful
3 difference and improve people's lives and families' lives.
4 Correct?
5 **A.** Yes. That's why I was promoting the structured
6 approach where you don't end with a score about someone being a
7 risk, you end with a safety plan and a risk management plan.
8 **Q.** Thank you. One of your recommendations, I think
9 recommendation number 2, if I can go to it in Exhibit 334, but
10 that's your recommendation for professional education and you
11 indicate:
12 Ensure that frontline professionals in
13 multiple systems such as health, mental
14 health, education, social services, and the
15 justice system, are up-to-date with current
16 information about domestic violence ...
17 Et cetera, et cetera. I appreciate that that's perhaps not
18 intended to be an all-encompassing, exhaustive list, Dr. Jaffe.
19 Would you agree with me that including education for firearm
20 officers would also fit within that recommendation?
21 **A.** Yes. And I assume most firearm officers are police
22 officers, so that would be certainly included. I think, you

1 know, every provincial ... I only know how it works in Ontario.
2 The OPP is the firearms officer and they're the contact, so I
3 would consider that's part of training for police.
4 **Q.** Okay. There's a distinction in Nova Scotia, so I just
5 wanted to make sure that you weren't intending to exclude
6 firearms officers, that certainly they would fall within the
7 breadth and depth of the professionals who you would be
8 targeting with that recommendation. Thank you.
9 **A.** Yes
10 **Q.** Okay.
11 **A.** For sure.
12 **(14:40)**
13 **Q.** You were asked about, or you talked about, consent and
14 privacy, and I think you had said, you know, we often tend to
15 work in silos ... what you've seen is that people are working in
16 silos and confidentiality is really an excuse for not
17 collaborating. And I wanted to expand on that a little bit more
18 because that does seem to have been a theme throughout, as you
19 would've seen in the file and certainly the evidence we've heard
20 from treatment providers who were doing their best, and they
21 felt that they needed to get consents to move the information
22 on. Certainly, with respect to being able to talk to

1 Shanna, we know Dr. Rahman, who would've seen Lionel at the
2 emergency room early in January, before the tragedy on January
3 the 3rd, indicated that he'd asked if he could speak with Shanna
4 to get further collateral information, but he was unable to do
5 that because Cpl. Desmond would not give permission. Certainly,
6 he had given permission lots of times before but, in that
7 instance, the answer was no.
8 So what's your practical solution in that kind of a
9 situation, Dr. Jaffe, when you have a treatment provider who
10 recognizes the need to reach out for additional information from
11 a spouse but is told by the patient that they're not allowed to
12 do that?
13 **A.** Well, I think, in those circumstances, I think you're
14 stuck. I mean those circumstances are very difficult and,
15 obviously, you can't go against it unless there's an imminent
16 risk of harm, you know. Then, obviously, it raises other
17 questions about reporting responsibilities either to Child
18 Protection or concern about a firearm in terms of imminent risk
19 of harm. Beyond that, I think I would often ... I think I would
20 consider trying to convince someone about the importance of
21 sharing information.
22 In our community, our Child Protection often pulls together

1 a community conference with different service providers to
2 provide safety and support for a victim of domestic violence in
3 more extreme cases that have been red-flagged, and the victim
4 initially says, I don't want my information shared but, often,
5 if it's explained to the victim or the perpetrator that, It's
6 going to take the whole village to keep you safe, you know,
7 that, you know, this information is critical for you and you own
8 it, you know, and we respect privacy; however, you know, helping
9 you means that we're also helping your family find ways to
10 support you. We also want to work with other service providers,
11 you know, in that community.
12 So I think there's cases like we've done where you can talk
13 to somebody about the benefits of sharing information because,
14 you know, the last thing somebody needs is having a system
15 working in silos. So there's some cases where I think friendly
16 persuasion might be required.
17 **Q.** Okay. And in the situation that happened with Dr.
18 Rahman at the emergency room with Cpl. Desmond that night, I
19 mean I think, as you said, he would've been stuck if Cpl.
20 Desmond did not give him the permission to contact Shanna, but
21 would you agree with me that that kind of a situation reinforces
22 why we need to be gathering/sharing/preserving information and

1 moving it forward so that Dr. Rahman, in that position, would've
2 had additional information which may have raised the level for
3 him of imminent harm such that he would have taken further
4 steps. Is that fair to say?
5 **A.** Yes, I think he should've had a summary of all the
6 background information. That should've been more readily
7 available to see the level of risk that was playing out. And,
8 again, I want to be very clear, I'm not talking about any mental
9 health professional in the Province of Nova Scotia, or anywhere
10 else, violating confidentiality, you know, I'm not talking about
11 being fast and loose with very confidential and personal
12 information. What I am talking about is talking to clients or
13 patients about the importance of information sharing to keep
14 them safe, and to keep their partner safe, and to keep their
15 family safe. So I think it's a different kind of message.
16 And even though, you know, you're describing a point in
17 time when it would've been hard to share information in
18 emergency, if that's what your patient is telling you, I think
19 these issues could've been addressed years earlier because,
20 although I'd never assessed Lionel Desmond, and I won't,
21 obviously, have that opportunity, everything I've read about him
22 tells me that he would've said, Yes, if somebody had said to

1 him, you know, I need to provide a summary of what we've done
2 for you so the next professional you see can benefit from all
3 our work and can move forward. I think that would've been
4 critical.
5 **Q.** Thank you, Dr. Jaffe, I appreciate your time, your
6 thoroughness, your dedication to this field and, as you shared
7 with us earlier the analogy with your children of keeping future
8 passengers safe, and that's why you do this work. Thank you.
9 **A.** Thank you.
10 **THE COURT:** Mr. Rodgers?
11
12 **CROSS-EXAMINATION BY MR. RODGERS**
13 **(14:46)**
14 **MR. RODGERS:** Thank you, Your Honour.
15 Good afternoon, Dr. Jaffe. My name is Adam Rodgers and I'm
16 representing the personal representative to the late Cpl. Lionel
17 Desmond.
18 **A.** Good afternoon. Good to meet you.
19 **Q.** You as well, and thank you for your testimony so far
20 and your document, your report.
21 Dr. Jaffe, you noted before, this morning, that some of
22 this evidence and the material will be difficult for the family

1 to hear and process; and, certainly, I can tell you it is, but
2 it also, I'd say, reflects some of what they've been saying from
3 the start, from the time of the tragedy and, indeed, even before
4 that, and this family is one that is determined to get answers
5 and to seek changes so that this doesn't happen again to another
6 family in another community. So, certainly, the report is
7 welcomed in that regard and from that perspective.
8 Doctor, the last witness, Dr. Theriault, forensic
9 psychiatrist, I went through some evidence that I think reveals
10 a pattern ... well, reflects a pattern of observations of other
11 medical professionals of dissociative episodes with Cpl. Desmond
12 as perhaps a subtype of his PTSD. I'm not going to ask you
13 anything about any of that, though I'm going to be talking about
14 that in my closing submissions, you know, how that condition may
15 have manifested itself over the final hours, or even perhaps
16 longer, of Cpl. Desmond's life, but I do wish to confront or to
17 talk about your report in its own terms, so I'm not going to be
18 talking about any of those dissociative episodes. I'm not sure
19 if you would have expertise or thoughts on that in any event but
20 I just wanted to let you know that.
21 **A.** I actually am a licensed psychologist, so I would be
22 involved in ... psychologists are licensed to diagnose under

1 the DSM-V, so we do a lot of work similar to psychiatrists other
2 than we don't have medical degrees and we don't prescribe
3 medication but, certainly, I have many clients who are victims
4 of trauma, who suffer from PTSD, and may have many of these
5 symptoms, so this is part of my work.
6 **(14:50)**
7 **Q.** Well, that's good to know and it actually reflects
8 some of what we heard from Dr. Gagnon and Dr. Murgatroyd as
9 well, the relationship between psychiatrists and psychologists,
10 so that is helpful. And, Doctor, I can certainly say your
11 recommendations are very welcomed and no doubt, certainly, that
12 these are valuable recommendations with respect to domestic
13 violence.
14 Doctor, I guess I would start off by putting this to you.
15 It seems that domestic violence is one of several lenses through
16 which this situation might be viewed, but perhaps not the only
17 one and perhaps not the lens that goes to the real core of what
18 took place here. It seems to me that one might consider
19 domestic violence to be the result of something and that part of
20 what this Inquiry is seeking to do is to find out more about
21 that something and that that quest is a proper goal of the
22 Inquiry.

DR. PETER JAFFE, Cross-Examination by Mr. Rodgers

1 Now, I know, in your report, you say that, sort of a
2 summary finding, that the focus on mental health overshadowed
3 the reality of domestic violence but I guess I would ask you
4 this. I'm thinking of a cause-and-effect relationship and it
5 seems to me that if mental health issues in this specific case,
6 and in maybe others, were properly treated, that the domestic
7 violence concerns may have either disappeared, or certainly
8 dissipated, but the reverse would not be true.
9 In other words, that if Cpl. Desmond, or someone like him,
10 had domestic violence interventions had, you know, no access to
11 firearms, that sort of thing, that the mental health problems,
12 the mental health issues he was dealing with, would still
13 remain. Do you see what I'm getting at there?
14 **A.** Well, I think what my report should say to you is that
15 there's two problem areas. They're connected, but they each had
16 to be dealt with, so I'm not, you know, I'm not minimizing Cpl.
17 Desmond's mental health problems. They were severe,
18 significant, and they required appropriate treatment but what I
19 would argue is so did the domestic violence.
20 **Q.** And I know you've reviewed the evidence from the other
21 witnesses extensively as well. I just want to go through some
22 of it with you though, Dr. Jaffe, starting with pre-military

1 Lionel Desmond. We've heard evidence from his family members
2 and others that he was described as the comedian of the
3 household. From the time he could talk, he was always cracking
4 a joke, never a dull moment, that sort of thing; that he was
5 funny, loving, and caring, and genuine; that he was - the phrase
6 was - a community kid; that if he wasn't at home, he was
7 probably helping a neighbour do something or helping one of the
8 elders in the community. His older sister, Diane, described him
9 as a good kid that didn't ask for much in life. If there was a
10 snowstorm, he was out shoveling for somebody. If there was
11 firewood to be cut or piled, he was out doing that, helping
12 somebody out, and an active and good kid, and a harmless kid.
13 And then as he became older, like in his teenage years, she
14 described him as a kid to the kids; in other words, he would be
15 down on the floor playing with other kids, you know, and could
16 identify with their innocence, sit there and joke around and
17 play with them, and the kids all loved him as well.
18 And, in addition, Dr. Jaffe, we heard from Mr. Paul Long
19 who was the guidance counsellor and coach at the school and
20 coached Cpl. Desmond in track, described him as a great
21 teammate, a real morale-booster on a team and Mr. Long, in fact,
22 made one of the recommendations for Cpl. Desmond to join the

1 military. He described him as a good athlete, a great runner,
2 and good-natured, always lots of fun to have around, and a good
3 student in school too.
4 And, in addition, if we're bringing up right to the
5 military, Cpl. Orlando Trotter, who testified was in the same
6 company as Cpl. Desmond, who knew him in training, described him
7 in similar terms. So I guess you're familiar with that
8 evidence, Dr. Jaffe?
9 **A.** Yes. Yes.
10 **Q.** And then I mean the time in the military is clearly a
11 turning point. When he comes back from Afghanistan, his family
12 saw that he was different. There was testimony from Diane again
13 who said that, you know, her grandmother said his eyes looked
14 like crow eyes, that he wasn't playing with the kids anymore,
15 noise was a problem for him. So that was a real issue with him,
16 that pride had seemed to deteriorate from him and, you know,
17 when he came back, you know, his sister, Cassandra, said you
18 could tell that there was something deep and dark on his mind.
19 He wouldn't talk about Afghanistan. That sort of thing.
20 That reflects your understanding of the evidence does it,
21 Dr. Jaffe?
22 **A.** Yes. I've read all that evidence and I think you're

1 doing a good job summarizing it.
2 **Q.** So, you know, and this is an obvious point, I guess,
3 but that time in the military was a turning point in Cpl.
4 Desmond's life, in his psyche.
5 **A.** Yes.
6 **Q.** So other people in his family saw that difference in
7 him. We heard even Mr. Long, it was a second-hand conversation,
8 but he had, you know, discussed with Mr. Borden at a funeral
9 that Cpl. Desmond had changed. So there was people that noticed
10 a distinct change in him and even Cpl. Desmond himself. And
11 you've outlined this as well, that Cpl. Desmond was self-aware
12 enough to realize that he had changed, that there was a
13 difference in his own presentation and his own personality.
14 **A.** Yes.
15 **Q.** And, to his credit, many times, Cpl. Desmond sought
16 assistance, sought help, wondering what was going on in his
17 mind, in his life, and was forthcoming and active in trying to
18 seek care.
19 **A.** I made special note of that in my report.
20 **Q.** Yeah. I think it's important to state that, I think.
21 In your report, Dr. Jaffe, and this is on page 17. I don't know
22 if we need to go to it, but you talk about specific to the

1 military context when you're looking at, you know, the spectrum
2 of domestic violence, you know, signs, indicators, and such,
3 that some of the particular risks to military service in the
4 domestic violence context is that the person exiting the
5 military has to make an adjustment to non-military life; that
6 there may be ongoing financial dependency issues; ongoing mental
7 health issues. Sorry, it's on page 17 if we're looking at it.
8 And, certainly, we can look to Cpl. Desmond's medical
9 reports in life and see some of those certainly manifesting
10 themselves. The adjustment to non-military life, ongoing
11 financial dependency, financial issues. We know, as his wife
12 was becoming a nurse and starting to work, that that was going
13 to change, but that had been an issue for several years at least
14 - mental health problems that he was experiencing and trying to
15 confront.
16 You mentioned the stigma regarding mental health preventing
17 some people from accessing or seeking treatment. It's not quite
18 so clear or I'll ask maybe for your comment on it. It doesn't
19 seem quite so clear in Cpl. Desmond's case except for maybe
20 those first few years after deployment where we know he didn't
21 seek treatment until 2011, a few years after his service.
22 **A.** Yes, I made a footnote on that page about how Cpl.

1 Desmond was different, that he seemed very open and actively
2 seeking help.
3 **Q.** And, of course, in the military, with military
4 services and increased risk of developing PTSD and related
5 mental health concerns such as depression and substance use.
6 So, certainly, some of those elements that you've identified as
7 broader concerns with respect to anybody that might go into
8 military service and emerge from that back into civilian life
9 were applicable to Cpl. Desmond. It was in your report, so I
10 would assume you would agree with that, Dr. Jaffe?
11 **A.** Yes.
12 **(15:00)**
13 **Q.** Some of the details ... And representing the personal
14 representative to Cpl. Desmond, I feel some responsibility to at
15 least clarify or note some of the comments and testimony with
16 respect to his actions. And I recognize that you note 21 of 40-
17 some factors, and that seven or more is a significant indicator
18 from your perspective, but I want to discuss a few of those with
19 you, Dr. Jaffe.
20 Certainly I think it's important to clarify the ... well,
21 to restate I guess, because I think you've talked about it
22 already. There's really only one allegation of physical contact

1 violence and that was the choking incident where I think we
2 might be able to safely conclude was a dissociative episode
3 where he woke up in the middle of the night from a nightmare and
4 seemed to have snapped out of it once his name was yelled and he
5 realized where he was and what he was doing. That seems to be
6 the only incident that we've heard about of any actual physical
7 contact violence between the couple.
8 **A.** Yeah, it's the one that's described most clearly and
9 consistently, there's some other passing references but they're
10 not clear.
11 **Q.** If we look to some of the other factors, certainly no
12 evidence of any sexual abuse or sexual kind of pressure of the
13 nature one might expect to see in some domestic violence
14 situations.
15 On the economic front, I just mention, Dr. Jaffe, if this
16 is significant to you. The couple had a joint bank account and
17 although there was some issues of, you know, at times, disputes
18 over money they did have ... it would seem like Ms. Desmond had
19 at least access to funds and access to a bank account most of
20 the time and that she had a support network of people around
21 her, her mother-in-law, her own mother, her own sister who was
22 here at times and out West at times, Diane Desmond as well for

1 support. So she did have some support around her as well.
2 One area, though, Dr. Jaffe, I guess I want to come around
3 to is this issue of childhood history of abuse. And we don't
4 really have great evidence on it other than we have one
5 secondhand comment from a medical report, a very brief comment,
6 but it's contradicted by family members who gave evidence and
7 even Mr. Long.
8 There didn't seem to be a theme to that emerging from any
9 of the other witnesses that would have suggested that Cpl.
10 Desmond had an unhappy or abusive childhood. I'm not sure if,
11 you know, I don't expect you to try to resolve those
12 discrepancies, but if it were to be concluded that, in fact, he
13 was not abused as a child or didn't suffer any kind of physical
14 abuse but, in fact, had a happy childhood, would that have a
15 significant impact on your conclusions or recommendations?
16 **A.** No. I think it's one of many factors and I took it
17 more seriously because it's unusual for mental health
18 professionals to note that in a file unless they have a report
19 directly from the patient or client, so I indicated that. But I
20 think whether it's 20 risk factors or seven there's too many.
21 **Q.** Sure. Sure. And as I say, I don't disagree with the
22 final conclusion.

1 There was another issue, you noted drugs and alcohol and
2 certainly there's evidence that at times Cpl. Desmond was
3 consuming too much alcohol by his own admission and he sought
4 help in that regard.
5 I'm not so clear that during late 2016 that that was ... I
6 mean, if you have an alcohol issue perhaps you always have an
7 alcohol issue but it didn't seem like he was consuming to excess
8 at that time. And, in fact, I think at the New Year's party
9 where the truck went off the road, he was the designated driver
10 on that occasion.
11 But, again, I assume this ... I'm not trying to say this
12 should go to the core of your recommendations, I just feel it's
13 important to bring out some of the contradictory evidence.
14 **A.** I understand what you're doing and I respect, you
15 know, what you're sharing.
16 **Q.** Thank you. There was another one, Doctor, the
17 questions of suicide and this is something I want to talk about
18 in another ... take it down another slight sidetrack.
19 He was asked at just about every time he went to see a
20 psychologist or psychiatrist whether he was having suicidal or
21 homicidal ideations and he always said no. You know, basically
22 he always said no. There was the report, of course, where

1 Shanna called to New Brunswick and the police showed up and took
2 his guns and Cpl. Desmond went to the hospital. The medical
3 records from that night shows that Dr. Ginn saw him for about 20
4 minutes and then discharged him. Other than that he seemed to
5 deny suicidal ideation or homicidal ideation on a pretty regular
6 basis.
7 The question for you is this: Is there any danger,
8 concern, problem with asking somebody all the time, every week,
9 if they have kind of ideation or what's on their mind? Does
10 that implant an idea in any way? What does your research or
11 study suggest on that?
12 **A.** No, you don't implant ideas about suicide by asking
13 the question. I think you're ... given the history, Cpl.
14 Desmond and the depression, the PTSD, would be a normal thing to
15 be reviewing and asking him about so I don't think that triggers
16 a suicide.
17 And there are ... I mean, my review of the file without
18 going into the details is there's very mixed picture on that.
19 You know, clearly when somebody says to him, you know, Are you
20 planning to kill yourself? You know, generally he says no, even
21 when, you know, Shanna calls the RCMP and he's told her,
22 according to her reports, that he's made a pretty clear

1 reference about going to the garage and a pretty clear reference
2 in her mind about a pending suicide. So there's certainly mixed
3 messages. He's dropping lots of hints, making lots of comments
4 about life not worth living or, you know, they're going to find
5 him in a body bag. You know, there's lots of things he's saying
6 which concern others.
7 When he's in front of many of the mental health
8 professionals and they ask him, Are you planning to kill
9 yourself and, if so, how and, you know, he tends to say no. So
10 there is a bit of mixed picture. There's multiple
11 interpretations. Sometimes people don't want to say it because
12 they don't want to be institutionalized. Certainly later on he
13 became aware that if he says he's suicidal he's going to lose
14 access to weapons. Obviously based on the RCMP, you know,
15 involvement and his guns being taken away and the subsequent
16 argument he had, I think, with his father-in-law he also
17 realizes that saying yes to that may have implications. I'm
18 speculating about multiple reasons why people may disclose
19 certain things at certain points in time to different people.
20 **Q.** The concussions, Dr. Jaffe, in your research we have
21 indications that Cpl. Desmond suffered multiple concussions,
22 probably three concussions during his service training and in

1 combat. How does that manifest itself or how does that impact
2 the risk of domestic violence?
3 It seems just from what we know of concussions it can
4 affect how somebody can be around crowds, around noise, flat
5 affect, lack of patience, that sort of thing. Is that an
6 independent risk factor or an independent thing you would look
7 at in terms of domestic violence risk?
8 **A.** Yes, I think concussions are significant. So
9 throughout the file it's talked about. There's never the final,
10 you know, neuropsychological examination but certainly he's
11 reporting significant injuries that would obviously give concern
12 about the potential for concussions. And certainly in the
13 research, you know, concussions, brain injuries may be
14 associated potentially with someone's ability to organize
15 themselves, manage their impulses. So certainly it would be a
16 worrisome sign.
17 **Q.** And I know I said I wouldn't talk about dissociation,
18 but PTSD with dissociation, Doctor, I guess you'd know sufferers
19 of that condition have elevated rates of suicide and functional
20 impairment as well. And so if you were looking at a patient
21 that was suffering from PTSD and there was indication that there
22 were flashbacks, nightmares, dissociative episodes, would that

1 raise the level of concern in your view?
2 **(15:10)**
3 **A.** Yes.
4 **Q.** Now, Doctor, this is somewhat of a separate topic but
5 with respect to domestic violence, there's some evidence that
6 Cpl. Desmond was trying to keep his wife and child away from, you
7 know, his in-laws' household where there had been allegations of
8 violence and some evidence of a history of violence. Is this
9 something ... how do you see those kind of scenarios manifesting
10 themselves in broad terms? I don't think you would probably have
11 enough background maybe or evidence on this situation to make
12 specific comments. But, you know, if there's been a history in
13 one family, one side of the family, is it ever ... you know, what
14 happens in that kind of case? If you're ... you know, the next
15 generation, is it inter-generationally likely to continue or is
16 ... how often does somebody say I'm going to put my foot down and
17 putting a stop to this? You know, I'm going to have a clean
18 break and live a different life.
19 **A.** I'm not sure I follow your question. I'm not sure.
20 You're talking about Lionel Desmond getting a clean break? I'm
21 not sure who you're talking about.
22 **Q.** There's some suggestion that, you know, Cpl. Desmond

1 exhibited some signs of domestic violence behaviour, but there's
2 also evidence that he was trying to stop a cycle of domestic
3 violence behaviour and protect his wife and family, his wife and
4 child, from a household where that had been present. Is that
5 something that you see manifest itself in similar cases?
6 **A.** Let me just break up that question in two ways. First
7 of all, I'm not sure what the evidence is about Shanna's family
8 and what are facts and what's in evidence. Like, my review of
9 the file I think the thing that would concern me would be
10 conflict between the two families. That obviously Shanna and
11 Lionel, using their first names, you know, would need all the
12 support they could get. So obviously an additional stressor
13 would be any conflicts between the two families.
14 I'm not sure I have an opinion about specifically whether
15 Lionel Desmond was trying to save Shanna from something. On a
16 more broad base, yes, domestic violence can be inter-
17 generational. Domestic violence, people who grew up with
18 violence are more likely to either repeat that violence as a
19 perpetrator or may more likely feel trapped in an abusive
20 relationship because of what they've grown up with. So
21 definitely violence has an impact from one generation to the
22 next. So that's a more sort of general answer without the

1 specifics of the facts in this case.

2 **Q.** When we look to the specifics, Dr. Jaffe, in this case,
3 you know, you've identified different issues such as depression,
4 obsessive behaviour, prior threats to commit suicide,
5 vulnerability, some sexual jealousy, alcohol use, unemployment,
6 these all arose after military service, after Cpl. Desmond's
7 military service. You answered my friend Ms. Miller's question
8 that there's really no evidence of these issues arising in any
9 context prior to that.

10 So I guess the big question that emerges from that or the
11 real question, Dr. Jaffe, is what was it and what is it about
12 seven months in Afghanistan that turns this, you know, sweet boy
13 who shoveled snow for his elderly neighbours, who played on the
14 floor with his young nieces and nephews, brought joy and
15 positivity to every room and team he was on, married the girl
16 down the road, his high school sweetheart, how does war turn that
17 person into somebody who is angry, deeply depressed, paranoid and
18 delusional and who ultimately saw no other way out? Like how
19 does that happen and what can we do?

20 **A.** Well, I think there's lots of evidence, including my
21 report, that we recognize that military service for many people
22 you pay a price when you're exposed to horrific events and death

1 during a war. Obviously, you come home and in this situation an
2 individual suffers from extreme PTSD, his mental health problems
3 affect him in a very profound way, affect his mood.
4 You know, he loses his livelihood. I think one of the
5 issues I addressed earlier, also loses his identity from pride of
6 being a man and being a soldier to suddenly being unemployed,
7 worried about where he's going to live, how he's going to manage
8 financially, whether that's realistic or not, that's what he's
9 feeling.
10 And then I think one of the challenges for any individual
11 situation is he's then ... you know, sees he's losing his wife
12 and his daughter. Obviously there's talk of separation. He's
13 worried about his future as a spouse, as a father, so he's having
14 great difficulty dealing with the idea of separation. Pre-
15 occupied with thoughts about his wife being unfaithful, being
16 jealous, you know, having these frightening dreams. So there's
17 multiple factors that eventually lead him down the road to this
18 outcome.
19 I think one important point I think that you raise that is
20 important to make is that not everybody who ends up in a
21 relationship where there's domestic violence or domestic homicide
22 necessarily has demonstrated that throughout the course of the

1 marriage. You know, many people report, you know, falling in
2 love with someone, having, you know, a happy courtship period and
3 talking about the early parts of the marriage being fine and then
4 things changing because of a number of factors.
5 So I think one of the things that I would speculate on and
6 it's more than speculation because Lionel Desmond says this is in
7 a variety of ways that he's lost a sense of purpose and sense of
8 meaning. You know, he doesn't feel he belongs in the community,
9 losing his wife, potentially losing his daughter, so he's going
10 down a spiral. Doesn't know how to deal with the separation. So
11 I think there's multiple factors.
12 I think he describes it in many different ways in terms of
13 the mental health professionals he sees and also in the text
14 messages or posts that he has on Facebook, he's describing a
15 sense of desperation.
16 **Q.** Mmm. You know, our responsibilities in a way give our
17 lives meaning and he didn't have significant meaning in his life
18 at that time it seems or would you ... do you agree with that,
19 Dr. Jaffe?
20 **A.** Yes, and actually it's stated in a variety of ways in
21 the report. And actually I quote one of the reports, I think it
22 might have been in the discharge summary from Ste. Anne's, is

1 that he lost his sense of meaning and a sense of belonging. So
2 he was certainly desperate and the last thing he had left was
3 Shanna and Aaliyah and he was fearful of losing them too, and so
4 I think near the end he became more and more desperate.
5 **Q.** We've heard from a few witnesses now that that is not
6 an uncommon feature of individuals who have been discharged from
7 the military, that they had a strong identity and an important
8 one certainly, and then now they feel like they lost an identity.
9 Do you have any suggestions or thoughts on how that might be
10 addressed, Dr. Jaffe? Whether, you know, keeping them involved
11 in some sort of mentorship role through, you know, Veterans
12 Affairs or through some other program to keep them engaged in
13 that identity somehow?
14 **(15:20)**
15 **A.** Yes. I think that would be critical. I mean there
16 needs to be some sort of assistance to get back to civilian life.
17 Again, many veterans make the transition and they find employment
18 and they maintain a happy marriage and family life, so many do
19 make that adjustment.
20 Obviously Lionel Desmond would be someone you'd red flag and
21 was red flagged as someone who is going to have great difficulty
22 making that adjustment and that continued with obviously all the

1 difficulty he was facing. So obviously he needed a chance for
2 meaningful employment and clearly that would have been a
3 priority.
4 I mean if he look at his list of needs, other than getting a
5 psychoeducational assessment there also needed to be some
6 direction about how he could meaningfully spend time. What could
7 he do to contribute to the community. You know, did he have
8 mechanical abilities, could he be a mentor, a youth leader, what
9 are ... obviously he needed a transition to something that would
10 give his life some sense of meaning and help him adjust to life
11 after the military. So I think that would certainly be a
12 priority.
13 **Q.** I'm thinking of the military context and this certainly
14 isn't all military members but would you see any benefit or would
15 you see whether it would be possible to do any kind of resilience
16 training before combat to ward off or prevent, you know, a PTSD
17 diagnosis from being generated in the first place?
18 **A.** Yes, I'm probably getting out of my area of expertise.
19 I deal with resilience and I certainly talk about resilience with
20 children and victims. I don't have any in-depth knowledge about
21 the preparation we do for soldiers before we send them to war so
22 ... But certainly you want to prepare them as much as possible.

DR. PETER JAFFE, **Cross-Examination by Mr. Rodgers**

1 I mean some of the things that Lionel Desmond described
2 experiencing at war in Afghanistan are so extreme that anybody,
3 even somebody in perfect mental health, would have great
4 difficulty coping with, so he certainly experienced the most
5 extreme conditions. So clearly you want to prepare people for
6 that role and then you want to provide the best care possible and
7 follow-up once they're re-deployed into civilian life.
8 I probably have more experience on the policing side of
9 things rather than military. I know that, you know, years ago
10 you just ... and I'll use this example, years ago you just became
11 a police officer once you qualified and there was very limited
12 training for what it was going to do to your mental health and
13 sense of isolation. And I know we've come a long way. There's
14 been a lot of inquests and reviews into PTSD in policing and the
15 things you have to do to prepare police officers for that ongoing
16 role and how it's going to impact them and how it's going to
17 change their lives, the things they're going to see.
18 So parallel to that, you know, I think the same things need
19 to apply to the military. But I want to be clear I'm not an
20 expert on what we do or don't do to prepare our soldiers.
21 **Q.** No, that's fine. What about resilience in terms of
22 domestic violence? So that a person, you know, going into combat

1 is going to be aware, you know, you're going to change. You're
2 going to be a different person when you come back. Here are some
3 of things to watch for in yourself through this lens of domestic
4 violence. You know, you're a married man with a family, you're
5 going to have to think about this stuff and watch your own
6 behaviour in this way. Is that something that happens and how
7 well developed is it?
8 **A.** Yeah, again I can only speak to policing, I can't speak
9 to what the military does or doesn't do. But certainly, you
10 know, you're identifying certainly a critical theme.
11 I mean somebody has to be prepared. I don't know, I can't
12 speak to how well Lionel Desmond was prepared or how anybody
13 could be well be prepared for the extreme issues he was ... death
14 and dying and extreme circumstances he was exposed to in
15 Afghanistan certainly at an early age. I mean, he's still a
16 young adult. So, yes, I think there should be as much
17 preparation as possible and then certainly as much follow-up as
18 possible.
19 But I think the key in my mind in this situation is not only
20 follow-up with him addressing his needs, but also follow-up for
21 his family. Because his family, as everyone indicated and you
22 indicated and reviewing the evidence, he came back a changed man.

1 He came back an individual with, you know, multiple problems and
2 Shanna and Aaliyah and his family had to deal with those new
3 circumstances and find a way to try to manage him, try to find a
4 way to support him without triggering more anger or distress.
5 **Q.** We talked about resilience training prior to combat.
6 We've heard some evidence from a psychiatrist that it's important
7 if somebody has had a traumatic event, traumatic experience, to
8 intervene as soon as possible thereafter to try to deal with that
9 process in a healthy way if that's possible.
10 What about from a domestic violence perspective, would you
11 see benefit or would you, you know, from your research is there
12 any ... how important or is it important to intervene, you know,
13 immediately after combat experience to talk to these soldiers to
14 say here, you are now a different person, you're going to go back
15 into the world and here are some things you need to know in a
16 domestic violence context that you're going to have to watch for
17 in yourself?
18 **A.** Yes, I think it would be important to prepare somebody.
19 I do agree with the general principle that the intervention
20 should be early. I know ... and again I keep making reference to
21 the fact that I probably do more work with the police on this
22 issue than I do with military, I certainly see the aftermath in

1 the military.

2 But with police now there's mandatory debriefing with most
3 police services I work with. If you've been involved in a
4 shooting or a traumatic incident you can't say ... you know, your
5 senior office or someone will say we have a policy here about
6 debriefing we want you to talk to somebody. And you can't say,
7 Well, I don't need to talk to anybody, I'm fine because it's
8 expected. It's no longer up to the individual to decide if they
9 have a mental health problem or need to debrief, it's now assumed
10 traumatic experiences have an impact and everybody needs help and
11 everybody should start getting that help as soon as possible by
12 debriefing the critical incident that they've just been through.
13 So I would say the same thing would apply to the military.

14 **Q.** And do you think putting everybody through that process
15 and not just those who ask for it or those who are identified
16 would help to de-stigmatize the situation and, you know, allow
17 for that process to take place without or with less resistence?

18 **A.** Yes, I think it should be expected, and especially ...
19 I think I made the comment early, especially in a male-dominated
20 profession where you learn to just have a stiff, you know, upper
21 lip and just suck it up and carry on like nothing happened.
22 There's obviously a different reality. We have much more

1 information now about the impact of trauma, and not only the
2 short-term impact but also the ongoing impact.
3 **Q.** Another stigma, Doctor, or image people may have in
4 their minds is of the soldier returning from home, gets off the
5 plane, off the boat and the family is there and there's a big hug
6 and everybody is happy and they go home and they're happy. The
7 reality would seem to be much more complex than that.
8 Do you see some sort of a structured concerted effort to
9 prepare families for this reintegration as being important or how
10 important it might be from your perspective, to, you know, get
11 rid of that false idealization of that situation?
12 **A.** I think that would be essential and I think my report
13 speaks to that. Perhaps I didn't say that clearly enough but
14 it's clear to me that in reviewing the file that Lionel Desmond
15 was getting some excellent services. I was impressed with many
16 of the reports that were done and the support that he was
17 getting, you know, in Quebec and New Brunswick. There was
18 certainly quality interventions being made.
19 What I would say is that there had to be at least an equal
20 amount of effort put into Shanna and Aaliyah. That they needed,
21 you know, if not equal they needed a pretty heavy dose of the
22 same kind of counselling to understand, you know, how their

1 husband and their dad had changed.
2 And I could see in the notes, for example, how Aaliyah was
3 concerned about her dad, concerned about her dad's mental health
4 problems and I could see, you know, interactions reported where
5 she's like the adult, reassuring him, telling him you know,
6 there's going to be help. So clearly there's a burden on her and
7 a burden on her mother and it's an overwhelming situation for
8 them to be able to manage.
9 **(15:30)**
10 **Q.** Just a couple of other topics I want to cover with you,
11 Dr. Jaffe. One is the question of medical marijuana and cannabis
12 consumption. We've heard from Dr. Smith. We've heard from some
13 of the laywitnesses and you've probably seen the report, it's the
14 evidence from Mr. Greencorn and from Cassandra Desmond that when
15 they saw Cpl. Desmond when he was consuming cannabis, he seemed
16 to be calm, his old self, laid back and relaxed, more talkative,
17 and had better control of his thoughts. That was their
18 perception of him. So is this something that you study or you're
19 aware of studies into this from a domestic violence lens, Dr.
20 Jaffe, if it's something that's helpful or can be helpful?
21 **A.** Not really. I'm not up to date with the connection
22 between cannabis and domestic violence or cannabis as appropriate

1 treatment. I would say that, in general, increased drug use and
2 the increased alcohol use, you know, is obviously a risk factor.
3 But beyond that, I don't think I could provide helpful
4 information to the Inquiry about cannabis.
5 **Q.** The other evidence that I wanted ask you about, Dr.
6 Jaffe, was the art therapist at Ste. Anne's, Maria Riccardi. I
7 don't know if you've looked at that evidence or that report in
8 any detail or not but I found it very interesting in terms of
9 Cpl. Desmond's presentation. You know, sometimes it seemed like
10 he had a hard time describing his condition or his thoughts in
11 words, but here he was creating art projects which seemed to
12 reveal something about his thoughts or, you know, is that
13 something you see in, you know, with people that have concussions
14 or that have maybe cognitive issues or that just aren't
15 talkative. That maybe are more artistic than they are verbal.
16 **A.** Yes. I mean you have to meet your clients or patients
17 where they're at and certainly there's a lot of clients who are
18 nonverbal for a number of reasons but may be able to express
19 themselves in other ways through art. I think throughout the
20 file there's certainly references that your client, or Cpl.
21 Desmond, is having difficulty organizing his thoughts,
22 articulating his thoughts and feelings in a consistent way and

1 that appears to become more and more challenging. Certainly near
2 the end as he's reaching out for assistance, trying to give
3 people a clear picture of his history and the issues he's
4 struggling with. Obviously, it's a struggle and, obviously,
5 that's I think one of the reasons why Shanna appears to take over
6 in terms of my speculation.
7 **Q.** Yeah, she was certainly a spokesperson in several of
8 those meetings. The art projects I'm thinking of, so first of
9 all, Cpl. Desmond drew a superhero, which is not unusual for
10 military veterans, Ms. Riccardi told us, but he was doing art
11 projects on his family and he drew a picture of his daughter but
12 he wasn't satisfied with it, and before she could really stop
13 him, he tore it up and threw it away, he was unhappy with it.
14 But then he started another project and this was a woodburning
15 project, which is sort of slower work, it's more meticulous, and
16 she guided him through it. He took time with it, he never missed
17 a class, he worked extra on it and, you know, with that help, he
18 was, you know, with some guidance, he took a patient and
19 meticulous approach and he had something beautiful and meaningful
20 as a result. And she said she still remembered the project years
21 later. Does that tell you anything about his personality? It
22 seems symbolic to me of, you know, maybe what could have taken

1 place here with more patient and meticulous help.

2 **A.** Yes, I think it goes back to one of your earlier
3 questions. Because, obviously, at some point, as he was coming
4 back to civilian life, he obviously needed the neuropsychological
5 assessment but part of that also would be a vocational
6 assessment. It might look at, you know, what skills did he have,
7 what talents. For example, what you're describing, that might
8 have been an area, and I am just speculating, it could be an area
9 where he could have been more actively involved in work on crafts
10 such as, you know, the project he had undertaken. That might
11 have been a potential vocation outlet. He might have been
12 involved in mentoring others. And actually what's critical is
13 that when you think about vocational careers, you also are
14 thinking about people's personality, you know, potentially mental
15 health problems. So for Lionel Desmond, he described not liking
16 crowds, not liking noise. So he might have been better off, you
17 know, pursuing a career or a job that involved, you know, very
18 small groups or very quiet space, more peaceful space for him,
19 given, you know, his reaction to loud noises or crowds. So
20 that's something else.

21 Actually, I have, and this is more an anecdote which may or
22 may not be helpful, but I have a neighbour who has a severe

1 concussion and she can't handle loud noises or crowds. Like even
2 somebody scraping utensils on a dish, cutting meat on a plate,
3 like anything. And so she's actively involved. She's had a
4 neuropsychological exam and she is seeing a vocational counsellor
5 to try to find a career where she could use the talent she has
6 but have a workspace set up that wouldn't interfere with all her
7 symptoms. So that takes a lot of time for a thorough assessment
8 and thorough planning. I just use that as an example to the kind
9 of thought that has to be put into it.
10 **Q.** One can certainly imagine an alternative timeline,
11 Doctor, where Cpl. Desmond comes back, gets his own apartment,
12 slowly reintegrates back into the family and with that sort of
13 slow meticulous guidance of counsellors and things turn out quite
14 differently with some awareness of his own conditions. When you
15 look at the file and look at the material, do you see that
16 picture emerging with proper interventions at earlier stages?
17 **A.** Yes. I mean I certainly ... Most of the homicides I've
18 reviewed over my career, you know, the ending is not inevitable.
19 There are different pathways or different doors that could open.
20 There are often, you know, missed opportunities to create a
21 different ending. So I don't think the ending was inevitable. I
22 do think the ending on the course that everyone was on, you know,

1 the ending seemed predictable and preventable but I don't think
2 it was inevitable. Had there been, and again my opinion without
3 repeating myself, you know, had there been earlier, you know,
4 risk assessments, earlier interventions, you know, there may have
5 been a different course. And, again, the thing that I'm struck
6 in reading the file is how much Lionel Desmond wanted help, how
7 much he was reaching out. So certainly he's not ... I see many
8 other cases where individuals are in total denial and, you know,
9 don't want to change or don't want help but he was somebody who
10 definitely wanted help.
11 **Q.** Dr. Jaffe, thank you. Again, I will repeat what others
12 have said, thank you for your report in this matter and thank you
13 for your evidence and thank you for answering my questions this
14 afternoon.
15 Those are all the questions I have, Your Honour.
16 **THE COURT:** Thank you, Mr. Rodgers. Mr. Hayne?
17 **MR. HAYNE:** No questions, Your Honour.
18 **THE CHAIR:** Mr. Murray, do you have anything to return
19 to?
20 **MR. MURRAY:** I have no re-direct, Your Honour.
21 **THE COURT:** All right, thank you. Just for a record, I
22 will acknowledge that Dr. Jaffe was retained by the Inquiry given

1 his expertise in the area, particularly in the area of domestic
2 violence death review, and that's not to say he doesn't have
3 expertise that goes beyond that very specific topic. He has
4 reviewed a very large amount of documentation and has provided us
5 with a very thorough and comprehensive and very insightful report
6 with regard to the information that is before us and brought it
7 together in such a way that it is of great benefit to me as,
8 ultimately, I bear the responsibility for determining, writing a
9 report and determining what, if any, recommendations should be
10 made.
11 **(15:40)**
12 You sit here, you think that you know some things and you
13 have some intuitive skills yourself, and I'll say that, and maybe
14 I speak for everyone, in some of the circumstances, we think we
15 know and we do, and you confirmed that for us. In other
16 circumstances, you provided us with some insight and knowledge
17 that allows us to ... I don't like using the word but I will,
18 leverage what we think we know and to actual knowledge and
19 understanding in such a way that it gives us an opportunity, me
20 in particular, an opportunity to better analyze and assess the
21 information that we have before us and we do have a lot of
22 information.

1 Dr. Jaffe's evidence that we have heard today is accepted in
2 an expert capacity, as is his report, which will be read as an
3 expert report and the contents will be evidence on the Inquiry as
4 well.
5 Which leads me to thank Dr. Jaffe for all the time and the
6 effort that he has put into the preparation of the report and
7 the preparation for his evidence today. He has a remarkable
8 body of work over his career that we are today benefitting from
9 and we very much appreciate that.
10 Dr. Jaffe, thank you sincerely from all of us. I think, as
11 well, that part of the expression is, a beneficial legacy of
12 some of this work is that it may also provide a reference
13 document and material for Dr. Bowes, who is most recently
14 charged with the establishment of Domestic Violence Death Review
15 Committees in Nova Scotia. The legislation has been proclaimed
16 and the Regulations have been published and I'd expect that work
17 will be underway soon and I think we may actually re-engage Dr.
18 Bowes in some discussions with that regard. So that is an
19 additional benefit that your work provides to us; that is, the
20 Inquiry, to Dr. Bowes and, ultimately, to all Nova Scotians and
21 perhaps beyond that as well.
22 Again, thank you, Doctor. I appreciate your time.

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1 **DR. JAFFE:** Thank you for your very kind words, your
2 Honour, and best wishes in writing the final report.
3 **THE COURT:** Thank you.
4 **WITNESS WITHDREW (15:44 hrs.)**
5 **THE COURT:** Ms. Grant, I have a question for you.
6 **MS. GRANT:** Yes, Your Honour.
7 **THE COURT:** You have Exhibit 335. Could we put Exhibit
8 335 up, please? I'm going to ask you just to see if you can help
9 me sort through kind of a bit of a chain of this document, okay.
10 So this is a document that's dated February 12th, 2018. The
11 logo looks like it's Health Horizon. Is that what the logo is
12 from the EAP? Is that the insurer?
13 **MS. GRANT:** The logo is the EAP, and that's Canadian
14 Federal Public Service.
15 **THE COURT:** That's the EAP, all right. So that's the
16 federal, is it Federal Public Service Health provider?
17 **MS. GRANT:** Yes, the EAP program. How it manifests in
18 each department is different but that's the logo.
19 **THE COURT:** Okay, and so in the case of Cpl. Desmond,
20 this would have been a healthcare provider that was contacted to
21 provide services, would that be correct?
22 **MS. GRANT:** Yeah. So the EAP program is like any other

1 EAP, short-term counselling, call the 1-800 number.
2 **THE COURT:** Sure, okay. As I said, it's dated February
3 12th, 2018 and in the comment section it says:
4 I decided to speak to Zandra to know if she
5 had destroyed the file or still had it. She
6 let me know that this file has been destroyed
7 two years after closing as per our protocol.
8 I told her that we learned through the media
9 that there will be an inquiry about the
10 triple murder and the suicide and that
11 perhaps they will reach out to her. She
12 understands and took the opportunity to chat
13 a little.
14 Then there's the initials "CF". So would this be somebody
15 from the military, from the Department of National Defence, from
16 VAC? Who is reaching out to Ms. Pinette at that time?
17 **MS. GRANT:** So I don't have that in front of me. We did
18 provide a couple of letters to Inquiry counsel trying to explain
19 how the program works and how it would have worked in this case.
20 So ...
21 **THE COURT:** No, I'm just interested in who is actually
22 reaching out? Who would the person ... I realize we might not

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1 have the name but what would the person's title, what department
2 would they be in? Would they be within the EAP program? Would
3 that be a reach out from, Veterans Affairs, would it be a reach
4 out from CAF?
5 **MS. GRANT:** No, it would be Health Canada.
6 **THE COURT:** Health Canada would be reaching out?
7 **MS. GRANT:** So when the kind of call went out of this
8 potential inquiry, we did sort of document preservation, you
9 know, keep your documents. But, in this particular case, there
10 is a very specific protocol for when somebody contacts the EAP
11 program, whether you're me, as a Justice employee, or whether
12 you're whatever, you get in touch with a counsellor and then, of
13 course, it's government. So there's reporting obligations,
14 auditing obligations. But the counsellors themselves are
15 independent contractors. So what they will be doing is providing
16 a, Did I see Melissa on this date? Yes, she went for three
17 sessions, yes. And so there's no ... The government would never
18 get a copy of, like, the things that I would say to my EAP
19 counsellor, for example. So this would be more in the nature of
20 someone that's involved in the program that's reaching out to one
21 of their counsellors they go, heads up.
22 **THE COURT:** In Exhibit 335, in the comment box, the

1 person that put the information in the comment box, would that be
2 somebody within the EAP or would that be somebody within
3 government generally?

4 **A.** I think it's somebody from Health Canada that is
5 involved in the program.

6 **THE COURT:** So that would be government.

7 **MS. GRANT:** Yes.

8 **THE COURT:** So the government ... all right.

9 When you look at Exhibit 336, in the comment box, it's the
10 same formatted document, it's dated May 11, 2015 and, in that
11 comment box it's:

12 Three by five (something) equals eight.
13 Client going through medical release for
14 PTSD. Followed by a psychiatrist. (And then
15 it's) IBN base. Mental health condition
16 stable. Relationship issues. Estranged
17 relationship with wife.

18 And then there's the initials SC. So, presumably, somebody
19 from Health Canada would have put that in the box at that time,
20 the same as they did the box in 335?

21 **MS. GRANT:** No, I would suggest that that would be Zandra
22 Pinette that's putting that in.

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1 **THE COURT:** But that's not Ms. Pinette's document, is it?
2 **MS. GRANT:** Oh, sorry, no, it says SC, so, yeah. And the
3 three times five is that you would get eight sessions. So
4 whether or not ...
5 **THE COURT:** No, I realize that but that's why I asked
6 about 335, if it was somebody from Health Canada that's filling
7 in the comment box, I would assume they're filling in the comment
8 box in Exhibit 336 as well.
9 **MS. GRANT:** Yeah, that would make sense.
10 **THE COURT:** Fine. So Health Canada was aware at that
11 point in time that his mental health condition was reported as
12 stable, presumably from Ms. Pinette, but that Health Canada, or
13 whoever was getting this information, was aware that there were
14 relationship issues, there was an estranged relationship with the
15 wife, and that was the status of his personal relationship,
16 correct?
17 **(15:50)**
18 **MS. GRANT:** I'm not sure I would agree with that, Your
19 Honour, just because the purpose of this is not, or what
20 potentially you're suggesting in terms of awareness. It's a
21 billing relationship and so, in order to pay their bills, Health
22 Canada needs to know that I am seeing my EAP counsellor for a

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1 thing and if I saw and show up, then they pay (inaudible - not at
2 mic).
3 **THE COURT:** Well my point is this. It clearly says that
4 his mental health condition was stable. That's a report as to
5 his mental health stability, I would suggest. Somebody in Health
6 Canada has it. But there's also a report that there are
7 relationship issues, that it's an estranged relationship with the
8 wife.
9 **MS. GRANT:** So this is the rationale for extending it.
10 So you would get a couple of sessions and that there's a
11 rationale ...
12 **THE COURT:** No, I'm going to stop you. I understand
13 that's a rationale but my point is is the information as to his
14 mental stability is called stable but his domestic relationship
15 is, I'm going to use the word, anything but stable because
16 they're estranged.
17 **MS. GRANT:** I mean I think, Your Honour, that that's a
18 question for Zandra Pinette because she's the one that's actually
19 treating him.
20 **THE COURT:** Well that's why I asked who filled in the box
21 and that's why you suggested that it was somebody from Health
22 Canada put the comments in 335, which would suggest to me that

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1 whoever put the information in the comment box at 336 was likely
2 also someone from Health Canada, which suggests to me that the
3 government did, in fact, have some information about the status
4 of his relationship and the estranged nature of the relationship
5 with his wife. But if you think that can be clarified in some
6 way, I'll leave it to you. You don't have to do it today. You
7 might just want to look into it.

8 **MS. GRANT:** We have attempted to do that.

9 **THE COURT:** Okay, thank you.

10 Counsel, as I said the other day, we are waiting for a
11 report from the Health Association of African Canadians, acronym
12 being HAAC, they're referred to as HAAC. We expect that on or
13 about the 22nd of this month and then I expect we will reconvene
14 on the 29th of November for that week to hear additional
15 evidence. You can expect to get an email by way of an update and
16 copies of additional information as we move towards those dates.

17 Counsel should be working on their briefs because shortly
18 after I would expect that we will be setting a date for a filing
19 of them.

20 Yes, Mr. Hayne?

21 **MR. HAYNE:** Just on that point, Your Honour. As we do
22 have some deadlines coming up, including deadline for written

1 submissions, I'm sure the evidence of Dr. Theriault and Dr. Jaffe
2 will factor into that and I would just ask that efforts be made,
3 if possible, to expedite the transcripts of the evidence this
4 week?
5 **THE COURT:** I can advise counsel that the transcripts are
6 being prepared and, as soon as they're available and proofed,
7 they will be made available to counsel. You'll get an email and
8 they will be posted and so you will have them as quickly as we
9 can get them.
10 Thank you, Counsel, for your time. We'll adjourn for the
11 day. Thank you.
12
13 **COURT CLOSED (15:55 hrs.)**
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CERTIFICATE OF COURT TRANSCRIBER

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

Margaret Livingstone
(Registration No. 2006-16)
Verbatim Inc.

DARTMOUTH, NOVA SCOTIA
November 14, 2021